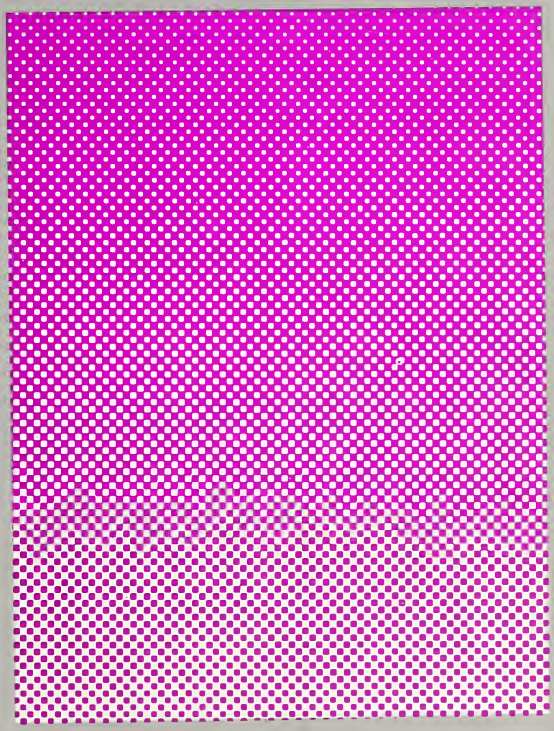
MEDICARE HOSPITAL MORTALITY INFORMATION



Volume III

Indiana - Maryland

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MEDICARE HOSPITAL MORTALITY INFORMATION

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VOLUME III

INDIANA - MARYLAND

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The Health Care Financing Administration (HCFA) was established on March 9, 1977, to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Peer Review Organization program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to ensure the effective administration of our programs in order to promote the timely delivery of appropriate, quality health care to over 56 million of the nation's aged, disabled and poor. The agency must also ensure that beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that agency policies and actions promote efficiency and quality within the total health care delivery system.

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The Administrator
Washington, D.C. 20201

INTRODUCTION

The nation's Medicare program, which is administered through the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, now has 31 million beneficiaries. One of HCFA's primary responsibilities is to ensure that Medicare beneficiaries receive quality health care. We believe that the publication of the information contained in this document will contribute to that end.

This particular information release, presents information to answer the question: "What is the actual death rate for each hospital compared to what would have been expected for that particular hospital given what we know of the characteristics of patients admitted?" The statistics are presented in the hope that they will serve the public and the hospitals in their common interest of improving quality of care.

The development of mortality statistics is a complicated and controversial task since the mortality rate at a given hospital reflects, among other factors, age, sex, diagnosis, and severity of illness of patients admitted to that hospital, as well as the purpose and quality of the care they received. Characteristics affecting health and the probability of death vary among the patient populations served by individual hospitals. Consequently, the mortality rates in different patient populations will vary.

The usefulness of this information depends upon the accuracy with which mortality rates can be predicted and the stability of these rates over time for each hospital. It is important to understand that the predicted values in the tables contained in this document are not a direct measure of the quality of care rendered in hospitals. There is one primary reason for this. We do not now have any direct measurement tool with which we can adjust fully for differences among hospitals in how severely ill their patients are. For instance, two hospitals might have very different death rates for patients admitted for stroke, even after we have adjusted for age and sex. This might happen because one hospital's stroke patients consist of a significant number admitted in a coma and are thus likely to die, whereas another hospital's patient population represents a broader spectrum of patients with cerebrovascular problems, or because these hospitals in fact provide different levels of quality. In addition, other factors affecting the probability of death in a particular case, e.g., family status/support, and overall health status are not included in the predictive model because information on them is not readily available.

When properly understood and used, this information can be useful; it can also be very misleading if it is interpreted incorrectly. The information simply describes one aspect of individual hospital performance--post admission mortality for Medicare beneficiaries. The information is not necessarily representative of a hospital's total performance in all aspects of patient care, and is best used to view experience in individual hospitals rather than making comparisons among hospitals. Individual hospitals may have very good reasons for their rates being higher than the ranges predicted by HCFA's model. Accordingly, it was important for hospitals to have an opportunity to review their specific information and to provide comments to HCFA and the public. We asked each hospital to prepare its comments on the information being released to the public, and we are including those comments in this publication.

The information is an important contribution to the health care community and should be reviewed by a wide range of individuals and organizations including hospital administrators, Peer Review Organizations, physicians and researchers. Among these audiences, perhaps the hospital administrator will find the information most useful--as a screening tool and in consulting with medical staff to evaluate a hospital's strengths and weaknesses. In this way, the information should lead to analysis and subsequent actions which will capitalize on areas of strong performance and strengthen areas where improvement is needed. For example, we expect that hospitals and their medical staffs, using established and newly emerging quality assessment techniques, will try to determine what useful information can be derived about how they function.

Consumers should read the explanations of the uses and limitations of the information, as well as any comments a hospital may have provided, and should carefully consider the different roles that different hospitals play in their community. For example, one hospital might have different death rates than another because it serves more severely ill patients, because it specializes in difficult illnesses, or because it is a trauma or emergency center.

The development and presentation of this information is an important part of HCFA's responsibilities in the health care community, and follows nearly a full year of effort. In making the information as accurate and useful as possible, we discussed the theoretical framework and statistical approach with a number of national experts in appropriate fields. As a result, we believe the models used in this work are reasonable and appropriate for the intent of the publication. In addition, the format for presentation, the process for sharing the information with individual hospitals, and the statistical methodology have been discussed at a series of meetings with leaders of organizations representing Medicare beneficiaries, doctors and hospitals, and a great many suggestions from these groups have been incorporated into the final approach.

We are continuing to do everything we can to make these types of information more useful to both the public and the health care professions. We are refining ways to use the information as a screening tool for "quality of care" purposes, and we are developing tools to adjust for the differences in disease severity highlighted earlier. In addition, because we recognize that mortality rates alone do not adequately measure how effectively a hospital cares for its patients, we will be developing other measures of outcome, such as the kind of medical treatment needed after discharge, to assess the performance of hospitals more fully.

We have begun what will be a continuing effort involving all interested parties to improve the accuracy of outcome predictions by refining the model and the methodology. This will contribute to assessment of and improvement in the effectiveness of medical services.

William L. Roper M.D.

William L. Roper, M.D.
Administrator

DESCRIPTION OF INFORMATION

Before reading the tables containing the hospital specific information and the comments provided by individual hospitals, it would be useful to understand the format and presentation of the information in this document.

The information is presented in alphabetical order by state and by hospital within the state. For each hospital, information is presented for overall Medicare patient mortality and each of 16 diagnostic categories. The information consists of the number of Medicare patients, the actual mortality rate, and a range of predicted mortality given the mix of patients. It would be helpful to describe how the numbers were derived and what they represent.

- Number of Patients. This figure represents the number of individual Medicare beneficiaries whose last discharge from a short term, acute care hospital in 1986 was from the hospital listed. The total number for each hospital is presented under the category "overall." Similarly, for each diagnostic category, the number of patients consists of the number of Medicare beneficiaries whose last discharge in 1986 was from the hospital cited and whose primary diagnosis fell within the specific diagnostic category. (Generally the number of patients in the sixteen diagnostic categories will total between 70 percent and 80 percent of the figure for "overall." The remaining 20 percent to 30 percent represent diagnoses that do not fall within the 16 diagnostic categories specifically studied.)

  Since only a patient's last hospital discharge is "counted" in the total number, HCFA's computation and that maintained by individual hospitals will generally differ. For example, if John Doe was a patient at Hospital A three times during 1986, the methodology used in HCFA's analysis counts only the last admission in the hospital's total. Normally a hospital will maintain statistics based on numbers of admissions and so would count Mr. Doe as three cases. In addition, in this example, if Mr. Doe were admitted later in the year to Hospital B (another acute care hospital) and then discharged in 1986, and this latter stay represented his last discharge for 1986, his case would be counted in Hospital B's total and he would not appear at all in Hospital A's count.

  The key factor to remember is that we are examining last hospital discharges in 1986. In some cases, this will necessitate the inclusion of patients admitted to the hospital in December 1985 or those who died in January 1987.

- Actual Mortality Rate. This figure presents the percentage of each hospital's Medicare patients who died within 30 days of the admission that resulted in the last-occurring discharge of the patient in 1986. (The percentage is rounded to the nearest whole percentage point.)

  Where, for example, Hospital A had a universe of 1000 patients whose last acute care hospital discharge in 1986 was from Hospital A, and 100 of these patients died within 30 days of that last admission, whether as hospital inpatients or after discharge, the actual mortality rate would be 10 percent. This rate includes cases in which a beneficiary was admitted to the hospital in 1985, was discharged in 1986 and died within 30 days of admission. It also includes those instances in which a beneficiary was discharged in 1986 and died within 30 days of admission even though the 30 day period extends into 1987. Cases in which the beneficiary was not discharged in 1986

are not part of the rate, even though an individual may have died in 1986 or have died within 30 days of last hospital admission. For example, a person admitted to a hospital on December 20, 1985, who was discharged on December 30, 1985 and whodied on January 2, 1986 is not part of the calculation since the person was not discharged in 1986. Similarly, a person admitted to a hospital on December 28, 1986 who was discharged on January 5, 1987 and died on January 8, 1987 would not be a part of the calculation even though he or she died within 30 days of a 1986 admission.

- Range of Predicted Mortality. This column gives an estimate of mortality rates for patients equal in number and similar in characteristics to those treated by the hospital. The range is derived in part by determining, based on national experience, the relative risk of dying associated with various patient characteristics: previous hospital admission(s), transfer status, age, sex, and presence of up to eight comorbid conditions (cancer, cardiovascular disease, cerebral degeneration/psychosis, pulmonary disease, renal disease, liver disease, diabetes, hypertensive disease) and by applying weights of the risk factors to the actual number of patients at the hospital to enable compilation of an expected mortality rate. This rate is converted, through statistical techniques, to a range of predicted mortality rates. It is important to note that the fewer the number of cases included in a given diagnostic category, the greater the uncertainty of the expected mortality range, and therefore, the wider the range. A larger number of cases yields greater precision, and therefore, a more narrow range of predicted mortality rates.

HOSPITAL COMMENTS

On September 21, 1987, HCFA mailed to each hospital its own mortality information and asked for comments by October 28, 1987. These comments are arranged alphabetically by state and are included in this publication immediately after the tables presenting information for all the hospitals in a given state. The entry for each hospital on the state charts indicates where to find the hospital's comments and presents a notation (asterisk) advising of the absence of hospital comments. The page number where the comments of the hospital are presented is given next to the name and address of the hospital.

The comments are generally reproduced as submitted by the hospital. However, some hospitals returned to HCFA, an annotated copy of the information sent on September 21. These annotated materials have not been reproduced in this publication, even in those instances where they were the only form of comments submitted by a hospital. The reason for not printing these materials is one of privacy. Information which would identify or possibly identify patients must be deleted, and consequently any remaining information would be very confusing and of extremely limited use, if not totally useless. Therefore, we have included a statement to identify instances when these types of materials have not been included. As mentioned earlier, it is extremely important that the information presented in the tables be reviewed in concert with the hospital's comments.

In any project of this size, there will be instances where hospitals did not receive the information for comment or did not receive it timely. In fact, many hospitals were sent second copies of their specific information in an expeditious manner to allow every opportunity for review/study and comment. Although we have received over 2,600 comments out of a possible 5,971, it is possible that some of the non-responding facilities never got the information or did not have adequate time to comment. However, we expect these instances were few in number.

INFORMATION SOURCES AND NOTES

It is important to note that this publication is based primarily on analysis of Medicare hospital billing information for calendar year 1986. While information about beneficiaries, was obtained from the Social Security Administration (SSA), the principal source for the analysis was the HCFA maintained MEDPAR file which contains information about each Medicare hospitalization. Hospitals submit such information to HCFA's fiscal intermediaries (which pay hospitals for the care provided to Medicare beneficiaries). The file is updated quarterly. It is estimated that billing information on approximately 95% of all Medicare discharges is included in the MEDPAR file within 6 months of the close of the calendar year. Accordingly, our analysis was based on information received through June 30, 1987.

In any large scale data base such as one dealing with Medicare hospitalizations, there will be gaps or inaccuracies. The fact that the files contain information on about 10 million hospital admissions to nearly 6,000 hospitals provides some assurance that for purposes of the statistical analysis conducted here, the information which might be missing or inaccurate is such a small portion of the total that it would have almost no impact on the results.

Nonetheless, while we feel that the information used in this analysis is quite thorough and complete, there are a few points which should be kept in mind as the hospital specific information is being reviewed.

- The information used is billing data and is only as good as the information submitted by hospitals as a part of the payment process. Although there is always a possibility that coding errors are included, the assumption is that hospitals do not make errors on billing forms which ultimately affect payment to them. Likewise, it is assumed that given the link to payment, hospitals have an incentive to submit bills promptly.

- The hospitals included in this analysis are short-term, acute care facilities which were identified by their unique provider number. All facilities which have a zero in the third column of their provider number are by definition participating in Medicare as short-term, acute care facilities. All other facilities--those with something other than a zero in the third column of the provider number--were excluded from the analysis. In some cases, hospital names suggest an orientation different from acute care. This does not mean the facility is inappropriately included in the publication.

- There is some information in the file which does not reflect the results of review by Peer Review Organizations (PROs), the entities charged with reviewing hospital services provided to Medicare beneficiaries. For example, one of the functions a PRO performs is to ensure that the diagnosis assigned to a particular case is accurate. The nature of the review and payment system is such that it is possible for PRO changes in diagnosis assignment not to be submitted to HCFA and associated in the MEDPAR file on as timely a basis as other billing information. Obviously, any major changes in diagnosis assignment which are not reflected in the data base would have a bearing on calculation of mortality rates in individual diagnostic categories and may also have a bearing on the extent to which presence or absence of comorbidities has been reflected accurately.

Some hospitals pointed out instances where the hospital's information did not agree with HCFA's, e.g., different date of death, cases of subsequent admission to another facility, or changes in diagnosis codes. The data base used in this analysis has not been revised to reflect these potential discrepancies. Rather we are examining all hospital comments to ensure that changes to our data systems and processes can be made when warranted so that future releases will be even more accurate. Readers are urged to review any hospital comments with a specific view toward these types of issues.

- The predictive model used in this effort does not explain all variability in outcome. Most notably, a measure of severity of illness has not been included in the model, and therefore, the predictive power of the model is less precise than it would be if such a measure had been available. Nonetheless, the information included in this document does legitimately contribute to the body of information about hospital performance.

Indiana

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
ADAMS CO MEMORIAL HOSP DECATUR IN 46733	IN-11	371	12	9-18	17	41	12-54	26	35	16-51	15	27	5-45	35	14	9-37	7	14	12-75	7	0	1-59	40	10	10-36						
BALL MEM HOSP ASSOCIATION MUNCIE IN 47303	IN-12	4006	12	9-15	225	22	16-32	127	32	18-35	91	15	10-29	231	23	19-31	165	44	30-47	100	21	12-32	308	18	13-25						
BARTHOLOMEW COUNTY HOSPITA COLUMBUS IN 47201	IN-13 *	1823	12	7-14	107	21	15-35	83	14	18-38	42	31	8-33	107	26	14-31	46	61	24-53	39	26	10-38	114	20	10-26						
BEDFORD MEDICAL CENTER BEDFORD IN 47421	IN-14	839	17	10-18	43	42	13-41	36	28	17-47	31	10	7-36	65	23	16-37	39	51	26-57	21	5	5-40	83	22	13-32						
BLACKFORD COUNTY HOSPITAL HARTFORD CITY IN 47348	IN-15 *	298	13	9-19	6	67	8-73	14	36	13-60	8	25	5-60	21	29	9-45	14	29	18-66	7	0	1-59	39	13	9-34						
BLOOMINGTON HOSP BLOOMINGTON IN 47401	IN-16 *	2273	13	10-16	240	30	22-38	84	31	19-40	56	18	7-29	122	18	16-31	96	36	27-48	30	17	6-36	191	21	13-27						
CAMERON MEMORIAL COMMUNITY ANGOLA IN 46703	IN-17 *	357	13	7-16	16	6	5-44	3	67	4-84	13	8	3-44	29	31	9-39	15	47	18-64	12	17	5-52	35	26	8-35						
CAYLOR-NICKEL HOSP INC BLUFFTON IN 46714	IN-18 *	1099	9	8-15	78	27	16-38	33	18	15-46	31	16	6-35	53	13	12-35	21	48	23-64	22	9	6-40	103	16	12-30						
CLARK COUNTY MEMORIAL HOSP JEFFERSONVILLE IN 47130	IN-19	1517	15	10-17	92	28	16-37	45	40	17-44	38	32	8-34	94	28	17-35	54	44	26-52	32	28	10-41	194	25	15-29						
CLAY COUNTY HOSPITAL BRAZIL IN 47834	IN-20	594	17	10-18	32	41	12-43	29	41	14-46	12	25	5-50	37	24	12-39	28	50	22-57	21	0	5-40	73	25	13-33						
CLINTON CO HOSP FRANKFORT IN 46041	IN-21	529	15	12-20	17	12	7-46	35	26	16-46	11	9	6-54	45	33	15-41	28	50	24-59	14	43	11-57	73	18	11-31						
COMM HOSP ASSN INC WILLIAMSPORT IN 47993	IN-22 *	198	15	9-20	10	30	7-59	14	36	12-57	5	0	0-70	18	22	7-45	2	50	7-96	4	0	1-74	26	12	10-43						
COMM HOSP OF ANDERSON ANDERSON IN 46012	IN-23	1327	13	8-15	67	25	15-39	48	27	18-44	29	3	9-41	67	31	14-35	31	48	24-58	33	21	9-39	119	19	12-28						
COMM HOSP OF INDIANA INC INDIANAPOLIS IN 46219	IN-24	5212	12	8-14	364	29	17-32	219	27	22-36	78	23	8-28	227	26	18-30	195	35	30-46	97	22	9-29	407	21	14-25						
COMMUNITY HOSPITAL OF BREM BREMEN IN 46506	IN-25	143	13	10-23	4	100	10-85	8	13	7-64	5	0	1-68	14	21	7-49	7	14	16-79	2	0	3-91	15	33	13-59						
CULVER UNION HOSPITAL CRAWFORDSVILLE IN 47933	IN-26	854	13	9-17	37	35	12-41	31	32	15-46	23	9	4-36	44	39	14-39	27	33	22-59	18	17	5-43	115	23	13-30						
DAVIESS COUNTY HOSPITAL WASHINGTON IN 47501	IN-27 *	762	18	10-17	27	44	12-45	54	43	18-43	22	18	5-38	55	24	14-38	28	57	22-58	32	16	5-33	88	22	12-30						
DEACONESS HOSPITAL INC EVANSVILLE IN 47710	IN-28	4073	12	8-14	275	24	16-31	135	31	20-37	63	14	6-27	195	27	16-29	143	42	29-47	102	19	9-29	321	19	13-25						
DEARBORN COUNTY HOSPITAL LAWRENCEBURG IN 47025	IN-29	1062	15	11-18	85	26	16-38	40	23	17-46	27	7	7-38	70	30	15-36	49	41	28-57	29	7	6-37	134	25	14-30						
DECATUR COUNTY MEMORIAL HO GREENSBURG IN 47240	IN-30	501	16	10-18	14	14	9-54	34	29	14-44	12	8	5-51	55	31	12-34	17	53	20-64	22	23	9-46	55	40	11-34						
DEKALB MEMORIAL HOSPITAL I AUBURN IN 46706	IN-31	588	13	8-15	41	27	8-35	21	43	13-51	21	10	6-40	31	32	10-40	22	50	20-60	24	4	5-38	47	15	7-30						
DUKES MEMORIAL HOSPITAL PERU IN 46970	IN-32 *	508	16	9-18	16	25	6-47	13	38	10-57	12	0	4-49	43	30	11-36	28	61	26-62	24	17	9-44	69	23	12-32						
DUNN MEMORIAL HOSPITAL BEDFORD IN 47421	IN-33 *	686	13	9-16	25	44	10-45	25	16	13-47	7	43	2-60	53	23	13-36	22	41	23-63	21	14	5-41	106	20	12-29						
ELKHART GENERAL HOSPITAL ELKHART IN 46514	IN-34 *	2251	11	8-15	191	24	15-31	108	24	21-40	65	23	10-32	137	22	15-30	104	36	28-48	38	8	6-33	137	15	11-26						
FAYETTE MEM HOSP ASSOC INC CONNERSVILLE IN 47331	IN-35 *	785	13	10-18	35	29	11-41	22	27	13-50	19	21	6-43	60	18	15-37	28	46	24-60	35	20	7-35	122	20	13-29						
FLOYD MEMORIAL HOSPITAL NEW ALBANY IN 47150	IN-36	2120	13	10-16	156	20	18-36	55	40	20-45	34	26	9-39	104	25	17-34	79	41	28-51	62	40	13-38	237	19	13-26						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
AOAMS CO MEMORIAL HOSP DECATUR IN 46733	7	43	8-71	2	0	3-91	9	0	1-50	1	0	0-100	63	5	2-15	14	7	0-42	6	0	0-100	26	8	1-24	10	0	0-65			
BALL MEM HOSP ASSOCIATION MUNCIE IN 47303	39	21	7-41	38	53	23-56	118	8	5-17	19	0	0-75	448	6	3-9	209	4	1-10	44	2	0-16	342	6	3-8	260	2	1-5			
BARTHOLOMEW COUNTY HOSPITA COLUMBUS IN 47201	13	31	5-54	14	36	12-60	80	9	2-16	4	0	0-100	189	4	2-10	96	7	1-13	29	0	0-41	107	7	2-11	207	0	0-5			
BEDFORD MEDICAL CENTER BEDFORD IN 47421	7	71	8-72	12	50	17-69	16	6	2-36	1	0	0-100	79	10	2-14	39	0	1-20	1	0	0-100	84	10	2-12	33	6	0-19			
BLACKFORD COUNTY HOSPITAL HARTFORD CITY IN 47348	6	0	6-73	1	0	0-97	13	8	1-40	.	.		32	3	2-22	9	0	0-51	4	0	0-100	31	3	1-21	9	0	0-96			
BLOOMINGTON HOSP BLOOMINGTON IN 47401	19	21	8-51	21	38	17-58	85	8	4-18	11	0	0-100	274	4	3-9	128	3	1-11	42	0	0-91	141	6	2-10	101	5	1-8			
CAMERON MEMORIAL COMMUNITY ANGOLA IN 46703	4	0	5-81	6	33	8-73	9	22	0-51	1	0	0-100	55	4	1-14	16	0	1-35	6	0	0-100	27	11	0-22	8	0	0-97			
CAYLOR-NICKEL HOSP INC BLUFFTON IN 46714	7	43	15-80	15	47	15-62	21	14	2-31	1	0	0-100	128	3	2-10	42	2	1-19	22	0	0-98	93	1	2-11	117	1	0-7			
CLARK COUNTY MEMORIAL HOSP JEFFERSONVILLE IN 47130	30	37	11-48	8	50	11-71	50	4	3-20	2	0	0-100	155	6	2-10	79	8	3-16	15	0	0-100	123	2	2-10	82	4	0-9			
CLAY COUNTY HOSPITAL BRAZIL IN 47834	16	44	10-57	9	22	13-71	25	4	2-27	.	.		57	9	1-14	22	9	1-29	7	14	0-100	53	6	1-15	15	0	0-53			
CLINTON CO HOSP FRANKFORT IN 46041	5	40	5-75	18	22	18-62	23	4	1-28	3	0	0-100	56	2	1-15	27	0	1-25	3	0	0-100	38	3	2-21	24	13	0-30			
COMM HOSP ASSN INC WILLIAMSPORT IN 47993	1	100	1-97	2	0	3-91	5	0	0-74	.	.		22	14	2-29	7	0	0-71	1	0	0-100	18	11	1-31	5	0	0-94			
COMM HOSP OF ANDERSON ANDERSON IN 46012	12	17	7-57	20	45	18-61	49	6	3-21	14	0	0-89	143	7	3-11	77	6	1-14	15	0	0-79	118	7	2-11	92	2	1-9			
COMM HOSP OF INDIANA INC INDIANAPOLIS IN 46219	43	21	9-42	33	45	20-55	171	10	5-15	162	0	0-5	546	5	3-8	161	9	2-12	32	0	0-34	397	7	2-7	450	1	1-4			
COMMUNITY HOSPITAL OF BREM BREMEN IN 46506	1	0	0-97	1	100	1-97	1	0	0-99	.			14	0	1-37	4	0	0-89	.	.		14	7	0-37	2	0	0-100			
CULVER UNION HOSPITAL CRAWFOROSVILLE IN 47933	11	36	11-65	13	23	12-61	38	5	3-24	2	0	0-100	97	3	2-12	54	6	1-17	9	0	0-100	82	2	2-13	31	0	0-28			
DAVIESS COUNTY HOSPITAL WASHINGTON IN 47501	6	67	4-69	14	36	14-62	27	11	1-25	1	0	0-100	81	7	2-13	17	6	2-35	8	13	0-95	62	6	2-14	25	8	0-27			
DEACONESS HOSPITAL INC EVANSVILLE IN 47710	34	32	12-49	60	25	24-52	127	9	4-15	53	2	0-20	381	6	3-8	150	7	3-13	23	0	0-82	404	5	2-7	303	1	0-4			
DEARBORN COUNTY HOSPITAL LAWRENCEBURG IN 47025	15	20	11-60	13	23	14-63	21	10	1-30	7	0	0-100	135	7	2-10	38	13	1-20	5	0	0-100	101	5	2-11	47	2	1-15			
DECATUR COUNTY MEMORIAL HO GREENSBURG IN 47240	3	67	6-88	7	29	12-75	9	0	2-51	.	.		57	4	1-15	24	0	1-27	4	0	0-100	38	5	1-18	12	0	0-70			
DEKALB MEMORIAL HOSPITAL I AUBURN IN 46706	8	63	8-68	9	22	9-65	24	13	2-28	.	.		74	4	1-12	21	0	0-31	12	0	0-100	37	5	1-18	21	0	0-40			
DUKES MEMORIAL HOSPITAL PERU IN 46970	5	40	2-71	6	50	9-75	13	8	1-40	1	0	0-100	77	5	2-13	14	0	0-40	6	0	0-100	31	10	1-22	11	0	0-55			
DUNN MEMORIAL HOSPITAL BEDFORD IN 47421	8	25	4-62	5	20	9-80	19	5	2-32	.			81	6	2-14	21	0	1-29	11	0	0-97	81	5	2-13	21	10	0-28			
ELKHART GENERAL HOSPITAL ELKHART IN 46514	18	22	7-50	16	31	19-65	59	12	4-21	4	0	0-100	208	3	2-9	137	2	1-11	33	0	0-28	143	1	2-10	191	2	0-5			
FAYETTE MEM HOSP ASSOC INC CONNERSVILLE IN 47331	22	18	9-49	12	17	15-66	12	0	1-42	1	0	0-100	115	3	3-13	21	5	1-30	14	0	0-99	69	3	1-13	19	5	0-40			
FLOYD MEMORIAL HOSPITAL NEW ALBANY IN 47150	21	19	8-49	9	78	10-67	66	9	4-21	16	0	0-93	195	6	3-11	119	9	2-14	20	0	0-68	214	2	3-9	119	1	0-7			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	Comment/ Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
GEORGE ADE MEM HOSP BROOK IN 47922	IN-37 *	132	11	9-22	8	50	8-66	3	0	3-83	3	0	2-81	8	25	4-59	2	0	1-89	7	14	2-60	13	15	8-53
GIBSON GEN HOSP PRINCETON IN 47670	IN-38	537	15	9-18	30	23	11-43	22	23	13-49	12	17	2-45	33	30	11-39	25	44	20-57	19	21	8-47	67	25	13-34
GOOD SAMARITAN HOSPITAL VINCENNES IN 47591	IN-39	2604	10	9-15	199	21	17-34	100	16	20-39	47	19	12-38	127	24	15-31	81	43	28-51	66	17	8-31	229	19	14-27
GOSHEN GENERAL HOSPITAL GOSHEN IN 46526	IN-40	1191	11	8-15	85	18	12-32	54	26	18-43	49	2	5-28	58	24	13-35	59	59	28-53	17	12	7-48	86	19	12-31
GREENE COUNTY GENERAL HOSP LINTON IN 47441	IN-41	638	17	11-19	26	46	12-47	28	36	17-51	17	47	10-51	61	25	12-33	55	47	26-52	16	19	6-46	68	9	10-30
HANCOCK COUNTY MEMORIAL HO GREENFIELD IN 46140	IN-42	913	13	10-17	45	22	17-45	35	23	16-46	16	38	6-46	53	25	13-36	45	36	26-55	27	37	8-41	77	22	11-31
HARRISON COUNTY HOSPITAL CORYDON IN 47112	IN-43	485	15	10-19	28	39	10-42	26	27	14-48	7	0	5-64	30	20	10-40	29	24	23-58	19	21	6-43	69	28	13-34
HENDRICKS COUNTY HOSPITAL DANVILLE IN 46122	IN-44 *	1069	16	10-18	71	30	14-37	58	26	16-39	36	19	8-35	63	19	13-35	41	27	25-55	25	28	8-42	148	28	14-29
HENRY COUNTY MEMORIAL HOSP NEW CASTLE IN 47362	IN-45 *	1086	14	9-16	58	24	11-35	50	36	16-41	43	26	8-33	74	24	14-34	65	38	26-50	21	19	4-39	87	20	11-30
HOLY CROSS PARKVIEW HOSPIT PLYMOUTH IN 46563	IN-46 *	495	13	8-17	24	21	9-44	25	20	12-47	13	15	2-44	42	26	13-39	18	39	17-60	32	6	5-34	46	30	10-35
HOWARD COMM HOSP KOKOMO IN 46901	IN-47 *	833	12	6-14	48	25	13-39	20	30	12-50	22	18	4-36	39	33	11-38	31	45	21-55	18	11	3-39	65	26	12-33
HUMANA WOMEN S HOSPITAL IN INDIANAPOLIS IN 46260	IN-48 *	36	0	1-21	7	0	2-60	.	.		.	.		.	.		.	.		.	.		1	0	0-100
HUNTINGTON MEM HOSP HUNTINGTON IN 46750	IN-49 *	405	18	10-19	35	20	12-42	28	32	14-48	4	25	2-75	43	21	12-37	19	58	22-64	20	35	10-48	29	17	9-39
INDIANA UNIVERSITY HOSPITA INDIANAPOLIS IN 46202	IN-50	1844	8	7-14	196	13	16-33	29	21	16-49	40	18	11-38	42	21	14-41	51	27	24-51	17	6	6-46	69	16	13-34
JASPER COUNTY HOSPITAL RENSSELAER IN 47978	IN-51 *	453	12	9-17	27	15	9-42	13	15	9-55	8	13	5-60	26	27	13-46	22	32	24-63	10	20	3-52	36	28	10-37
JAY CO HOSP PORTLAND IN 47371	IN-52 *	517	15	9-18	22	32	9-45	28	29	14-48	15	20	5-45	26	15	9-41	27	59	24-60	24	25	10-46	44	20	9-34
JENNINGS COMMUNITY HOSPITA NORTH VERNON IN 47265	IN-53 *	283	18	9-19	8	63	6-63	8	50	9-66	3	0	2-82	21	43	11-48	11	45	15-67	14	21	5-48	52	25	10-33
JOHNSON COUNTY MEMORIAL HO FRANKLIN IN 46131	IN-54	983	16	10-18	62	27	16-41	37	41	17-46	20	30	6-41	73	16	16-36	41	22	26-56	28	29	7-39	111	27	13-30
KINGWOOD HOSPITAL MICHIGAN CITY IN 46360	IN-55 *	231	6	5-15	10	50	6-57	4	0	5-79	7	14	2-59	22	9	10-46	1	100	3-100	5	0	3-71	10	10	3-51
KOSCIUSKO COMMUNITY HOSPIT WARSAW IN 46580	IN-56 *	780	14	9-17	47	21	9-34	30	33	15-48	23	17	7-41	50	34	13-36	38	42	25-56	27	30	6-38	80	18	13-32
LA PORTE HOSP LA PORTE IN 46350	IN-57	1315	11	9-16	93	19	11-31	62	24	17-41	42	12	7-32	78	15	13-32	43	44	27-57	33	15	8-39	118	19	12-29
LAFAYETTE HOME HOSP INC LAFAYETTE IN 47902	IN-58	1824	12	8-15	124	20	14-33	68	31	17-39	37	30	8-34	82	15	15-34	70	43	29-53	40	15	7-34	150	21	14-29
LAGRANGE COUNTY HOSPITAL LAGRANGE IN 46761	IN-59 *	313	18	8-17	13	31	8-54	13	31	11-58	10	30	3-51	26	38	9-41	11	64	15-67	11	18	4-51	47	28	8-31
MARGARET KENORICK MEMORIAL MOORESVILLE IN 46158	IN-60 *	294	0	1-10	.	.		.	.		2	0	0-93	.	.		.	.		.	.		.	.	
MARGARET MARY COMMUNITY HO BATESVILLE IN 47006	IN-61 *	416	17	10-19	20	35	9-47	30	43	17-50	11	18	4-52	29	28	10-41	9	33	11-67	9	11	3-55	51	27	13-37
MARION GENERAL HOSPITAL MARION IN 46952	IN-62 *	2147	12	9-16	146	24	15-32	85	34	20-40	50	12	7-30	132	27	17-33	75	41	26-49	76	13	12-34	209	20	15-28

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories												Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
GEORGE AOE MEM HOSP BROOK IN 47922	1	100	2-98	5	40	10-81	10	10	2-48	.	.		24	0	2-27	5	0	0-74	1	0	0-100	8	0	0-60	7	0	0-83
GIBSON GEN HOSP PRINCETON IN 47670	11	55	7-60	2	100	2-91	17	12	1-34	.	.		51	6	2-17	26	4	1-26	5	0	0-100	41	0	1-18	31	0	0-22
GOOD SAMARITAN HOSPITAL VINCENNES IN 47591	38	21	15-50	21	19	19-61	85	6	4-18	22	0	0-61	270	2	3-9	152	4	1-11	14	7	0-82	205	4	3-9	169	1	0-5
GOSHEN GENERAL HOSPITAL GOSHEN IN 46526	9	22	2-57	6	0	11-78	49	12	3-21	2	0	0-100	150	3	2-9	83	4	1-13	15	7	0-86	76	5	2-13	123	4	0-7
GREENE COUNTY GENERAL HOSP LINTON IN 47441	8	38	5-64	6	50	11-77	22	5	2-31	.	.		74	4	2-15	23	13	1-28	8	0	0-87	53	17	1-15	19	0	0-43
HANCOCK COUNTY MEMORIAL HO GREENFIELD IN 46140	12	33	6-56	24	21	20-59	27	11	4-31	1	0	0-100	120	5	2-12	45	0	1-18	7	0	0-99	66	6	2-15	57	0	0-13
HARRISON COUNTY HOSPITAL CORYDON IN 47112	5	0	1-72	3	33	4-85	17	18	3-37	.			62	3	1-14	16	0	1-35	5	0	0-100	39	5	1-17	8	0	0-96
HENORICKS COUNTY HOSPITAL DANVILLE IN 46122	8	38	8-68	11	27	12-65	38	8	2-23	3	0	0-100	116	8	3-12	70	0	2-17	21	5	0-87	79	3	2-14	29	0	0-22
HENRY COUNTY MEMORIAL HOSP NEW CASTLE IN 47362	10	0	6-60	15	33	13-60	24	13	3-31	6	0	0-100	115	6	2-11	64	6	1-15	14	0	0-98	92	3	2-12	31	6	0-21
HOLY CROSS PARKVIEW HOSPIT PLYMOUTH IN 46563	2	0	1-90	6	50	7-72	15	0	1-36	.	.		61	8	2-15	30	3	0-23	6	0	0-100	34	6	1-20	18	0	0-41
HOWARD COMM HOSP KOKOMO IN 46901	7	14	4-65	7	29	10-73	23	4	1-28	7	0	0-100	85	7	1-12	45	4	1-18	11	0	0-100	81	7	1-12	73	3	0-11
HUMANA WOMEN S HOSPITAL IN INDIANAPOLIS IN 46260	.	.		.	.		.	.		.	.		4	0	0-94	.	.		17	0	0-99	.			.	.	
HUNTINGTON MEM HOSP HUNTINGTON IN 46750	6	67	6-73	2	0	1-89	19	11	1-31	.	.		52	12	1-16	14	0	0-47	6	0	0-100	24	4	0-25	10	0	0-63
INDIANA UNIVERSITY HOSPITA INDIANAPOLIS IN 46202	40	15	4-37	6	17	8-74	21	14	2-30	20	0	0-82	122	7	4-15	42	0	1-19	17	0	0-55	213	8	3-10	206	1	0-5
JASPER COUNTY HOSPITAL RENSSELAER IN 47978	6	33	9-76	7	57	9-71	16	6	1-35	.			66	6	2-15	23	4	0-28	7	0	0-100	31	10	1-22	23	4	0-37
JAY CO HOSP PORTLAND IN 47371	11	36	9-62	4	25	7-82	4	25	0-79	.			60	7	2-15	15	7	2-37	8	0	0-100	49	6	1-16	29	0	0-24
JENNINGS COMMUNITY HOSPITA NORTH VERNON IN 47265	6	0	2-66	4	25	8-83	1	0	0-100	1	0	0-100	39	10	1-19	19	5	0-31	.	.		23	4	1-26	1	0	0-100
JOHNSON COUNTY MEMORIAL HO FRANKLIN IN 46131	12	17	7-57	22	36	12-51	43	16	3-22	4	0	0-100	122	7	2-11	55	5	2-19	16	0	0-88	81	5	2-12	39	3	0-21
KINGWOOD HOSPITAL MICHIGAN CITY IN 46360	1	0	1-97	1	0	2-98	.	.		16	0	0-87	13	0	0-41	5	0	0-99	2	0	0-100	12	0	1-41	13	0	0-73
KOSCIUSKO COMMUNITY HOSPIT WARSAW IN 46580	6	17	9-76	9	33	13-71	23	9	2-29	19	0	0-96	83	6	2-13	33	3	0-22	5	20	0-100	81	2	2-13	48	0	0-14
LA PORTE HOSP LA PORTE IN 46350	15	7	7-53	25	40	22-61	36	11	2-23	10	0	0-100	130	7	3-12	62	2	1-15	19	0	0-66	102	4	2-11	50	0	0-14
LAFAYETTE HOME HOSP INC LAFAYETTE IN 47902	20	20	8-49	33	39	18-52	63	13	3-18	23	0	0-76	184	6	2-9	97	2	1-13	27	0	0-65	133	5	2-10	150	1	0-6
LAGRANGE COUNTY HOSPITAL LAGRANGE IN 46761	3	67	3-84	1	0	0-97	4	0	0-80	1	0	0-100	37	5	0-18	12	8	0-50	2	0	0-100	18	6	0-31	7	0	0-67
MARGARET KENDRICK MEMORIAL MOORESVILLE IN 46158	.			.			2	0	0-97	.	.		54	0	0-14	.	.		.						83	1	0-9
MARGARET MARY COMMUNITY HO BATESVILLE IN 47006	8	75	15-76	4	0	7-82	16	19	1-35	.	.		37	3	1-18	12	0	0-45	4	0	0-100	40	13	1-18	9	0	0-91
MARION GENERAL HOSPITAL MARION IN 46952	20	35	8-50	15	40	16-63	71	6	4-19	8	0	0-100	246	5	3-10	117	4	1-12	35	0	0-44	166	5	2-9	112	1	0-7

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																													
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease											
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent								
MARY SHERMAN HOSPITAL SULLIVAN IN 47882	IN-63 *	521	14	9-18	15	47	7-49	31	23	15-47	11	27	4-51	51	31	13-37	18	39	20-64	14	7	5-48	50	22	11-35								
MCCRAY MEMORIAL HOSPITAL KENDALLVILLE IN 46755	IN-64 *	453	12	9-17	28	39	13-47	21	29	11-47	12	25	5-50	38	24	10-36	14	50	19-67	18	17	5-43	48	10	9-32								
MEMORIAL HOSP JASPER IN 47546	IN-65	740	11	8-16	47	32	13-40	25	44	13-48	15	13	4-44	65	23	14-35	27	22	22-58	38	21	9-37	63	14	9-29								
MEMORIAL HOSP LOGANSPORT IN 46947	IN-66	865	14	8-15	51	25	11-36	26	31	14-49	24	13	5-36	53	26	12-34	49	45	23-51	7	14	1-59	75	17	9-28								
MEMORIAL HOSP SOUTH BEND IN 46601	IN-67	3240	11	8-14	254	25	17-32	78	33	17-38	58	22	9-32	163	19	15-29	108	41	28-47	82	26	12-35	191	19	14-28								
MEMORIAL HOSP OF MICHIGAN MICHIGAN CITY IN 46360	IN-68	285	15	9-18	16	56	13-57	9	56	11-67	13	8	4-46	17	24	6-44	5	40	7-76	8	25	5-61	30	23	9-40								
MERCY HOSPITAL INC ELWOOD IN 46036	IN-69 *	434	19	11-20	21	38	12-50	31	32	15-47	12	25	6-52	40	25	14-41	20	55	20-61	19	0	7-45	59	36	12-35								
METHODIST HOSP OF INDIANA INDIANAPOLIS IN 46202	IN-70	5935	12	8-15	491	28	20-34	203	32	20-34	159	20	12-28	263	18	17-28	193	36	29-45	93	29	11-32	299	21	15-27								
METHODIST HOSP SOUTH LAKE MERRILLVILLE IN 46410	IN-71	1950	14	9-16	138	35	17-36	76	37	17-38	38	21	10-38	144	21	15-30	60	42	25-50	55	22	12-38	150	26	13-28								
MICHIANA COMMUNITY HOSPITA SOUTH BEND IN 46615	IN-72 *	592	12	8-16	36	31	11-40	16	19	11-53	20	20	5-39	42	17	11-36	13	38	14-63	34	9	5-33	63	14	10-31								
MORGAN CO MEM HOSP MARTINSVILLE IN 46151	IN-73 *	813	13	11-18	39	23	10-38	43	35	17-45	14	29	7-50	40	10	14-41	35	51	27-60	10	10	5-56	111	18	13-30								
NORTH CLARK COMM HOSP CHARLESTOWN IN 47111	IN-74 *	362	9	7-16	15	7	10-54	11	27	8-57	4	0	1-74	15	27	7-48	11	18	16-69	20	10	6-42	51	27	11-34								
ORANGE COUNTY HOSPITAL PAOLI IN 47454	IN-75 *	371	15	11-21	13	15	9-55	11	36	9-58	9	22	2-53	26	23	10-42	16	31	23-59	14	7	4-46	91	25	14-32								
OUR LADY OF MERCY HOSPITAL DYER IN 46311	IN-76	1133	10	8-15	45	18	13-41	38	24	16-45	28	11	8-39	62	16	13-35	33	39	22-55	40	28	9-36	119	17	12-28								
PARKVIEW MEMORIAL HOSPITAL FORT WAYNE IN 46805	IN-77	4376	10	8-14	364	21	17-31	175	25	22-37	86	15	10-30	182	28	16-29	158	36	27-44	61	18	12-36	253	20	13-26								
PERRY CO MEM HOSP TELL CITY IN 47586	IN-78	283	15	10-20	9	33	5-58	19	26	14-55	4	0	3-76	20	35	10-47	11	36	16-69	11	9	3-50	35	22	10-38								
PORTER MEMORIAL HOSPITAL VALPARAISO IN 46383	IN-79	2406	13	8-15	125	20	14-33	76	32	19-40	70	23	8-28	110	23	14-30	65	40	26-51	77	16	11-33	227	21	14-27								
PULASKI MEMORIAL HOSPITAL WINAMAC IN 46996	IN-80 *	365	15	9-18	23	35	11-47	25	20	15-50	6	17	3-65	24	54	8-40	9	44	13-70	7	0	1-59	41	17	11-37								
PUTNAM CO HOSP GREENCASTLE IN 46135	IN-81	668	15	11-19	30	23	12-44	41	41	16-44	18	22	7-45	50	38	14-38	33	42	23-56	17	6	4-43	87	21	16-35								
RANDOLPH COUNTY HOSPITAL WINCHESTER IN 47394	IN-82 *	231	10	7-17	5	80	8-77	7	0	4-62	4	0	2-74	16	19	6-45	8	25	14-74	7	14	4-63	29	14	6-35								
REID MEMORIAL HOSPITAL INC RICHMOND IN 47374	IN-83	2468	11	9-15	184	15	15-32	91	26	18-37	71	17	9-30	161	30	15-29	99	43	29-49	59	17	10-34	221	18	13-26								
RICHMOND STATE HOSPITAL GE RICHMOND IN 47374	IN-84 *	30	3	1-23	1	0	0-99	1	100	0-97	.	.	.	.	.	.	.	.	.	1	0	0-99	4	0	1-74								
RIVERVIEW HOSP NOBLESVILLE IN 46060	IN-85 *	984	10	8-15	54	15	13-38	26	46	15-50	28	11	5-33	33	21	13-42	38	42	26-57	24	17	6-40	135	13	12-27								
RUSH MEM HOSP RUSHVILLE IN 46173	IN-86 *	338	16	10-19	12	25	8-56	14	50	11-56	13	31	6-50	22	36	9-44	23	43	20-58	10	0	2-51	42	19	12-38								
SCOTT COUNTY MEMORIAL HOSP SCOTTSBURG IN 47170	IN-87 *	486	14	9-18	13	46	12-59	14	14	12-58	3	33	0-82	35	34	11-38	8	50	12-71	16	13	5-45	144	15	12-27								
ST ANTHONY HOSP MICHIGAN CITY IN 46360	IN-88	1224	12	9-16	83	22	12-33	57	25	17-40	34	15	8-37	96	20	13-30	32	47	23-56	35	26	7-36	106	16	10-27								

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
MARY SHERMAN HOSPITAL SULLIVAN IN 47882	5	60	2-71	9	22	8-64	21	10	2-32	.	.		54	9	2-16	29	3	1-24	6	0	0-100	60	2	1-13	20	0	0-38			
MCCRAY MEMORIAL HOSPITAL KENDALLVILLE IN 46755	6	0	5-70	4	25	6-81	17	6	3-38				63	5	1-13	21	0	0-32	5	0	0-100	33	0	1-20	6	0	0-91			
MEMORIAL HOSP JASPER IN 47546	8	25	9-69	1	100	2-99	25	12	3-30	9	0	0-100	66	3	2-14	24	0	1-27	13	0	0-100	47	2	1-15	70	0	0-11			
MEMORIAL HOSP LOGANSPORT IN 46947	6	17	7-74	9	33	11-68	34	6	3-24	.	.		110	7	1-10	41	10	1-20	26	0	0-95	63	5	1-13	67	0	0-11			
MEMORIAL HOSP SOUTH BEND IN 46601	25	8	10-49	19	47	20-63	78	8	3-17	45	0	0-49	302	3	3-9	85	4	2-14	36	0	0-46	455	4	2-7	224	1	0-5			
MEMORIAL HOSP OF MICHIGAN MICHIGAN CITY IN 46360	4	25	2-76	7	29	10-73	10	0	1-47	1	0	0-100	26	8	1-24	11	0	1-44	.			16	6	0-34	7	14	0-95			
MERCY HOSPITAL INC ELWOOD IN 46036	5	0	3-72	5	0	10-81	5	0	0-71	.	.		35	6	1-20	11	9	0-45	5	0	0-100	24	0	1-25	15	0	0-58			
METHODIST HOSP OF INDIANA INDIANAPOLIS IN 46202	98	15	9-36	42	45	26-59	116	17	4-16	278	0	0-3	372	8	4-10	218	6	2-11	46	2	0-15	548	5	3-7	390	2	0-4			
METHODIST HOSP SOUTH LAKE MERRILLVILLE IN 46410	17	29	9-54	39	41	22-55	32	6	3-26	2	0	0-100	186	5	2-9	107	5	1-12	13	0	0-100	231	6	2-8	96	3	0-8			
MICHIANA COMMUNITY HOSPITA SOUTH BEND IN 46615	6	67	3-68	10	40	10-65	8	25	0-54	3	0	0-100	55	5	1-15	32	9	1-22	8	0	0-97	29	0	1-22	45	4	0-15			
MORGAN CO MEM HOSP MARTINSVILLE IN 46151	8	25	7-66	29	38	21-57	23	13	2-29	2	0	0-100	107	12	3-13	69	0	2-16	9	0	0-100	60	0	2-16	28	4	0-35			
NORTH CLARK COMM HOSP CHARLESTOWN IN 47111	6	0	1-66	.	.		3	0	0-93	.	.		38	3	1-19	12	8	0-43	2	0	0-100	45	0	1-17	12	8	0-57			
ORANGE COUNTY HOSPITAL PADLI IN 47454	10	20	10-66	6	50	18-85	11	9	1-45	.	.		29	14	2-26	14	0	0-41	6	0	0-100	19	0	1-30	10	0	0-90			
OUR LADY OF MERCY HOSPITAL DYER IN 46311	6	50	3-68	28	21	22-59	22	9	3-33	.			93	4	3-14	33	6	2-24	14	0	0-88	93	6	1-11	62	5	0-11			
PARKVIEW MEMORIAL HOSPITAL FORT WAYNE IN 46805	25	28	10-49	26	42	20-58	154	9	4-15	16	0	0-92	403	3	3-8	188	4	2-11	34	0	0-83	408	5	2-7	530	1	0-3			
PERRY CO MEM HOSP TELL CITY IN 47586	8	25	8-69	5	40	11-82	10	10	1-47	.	.		29	3	0-22	13	0	0-42	2	0	0-100	24	4	1-25	3	0	0-99			
PORTER MEMORIAL HOSPITAL VALPARAISO IN 46383	33	27	12-48	43	23	22-53	57	12	4-21	10	0	0-100	239	7	2-9	155	8	2-11	19	0	0-95	200	5	2-8	134	3	0-6			
PULASKI MEMORIAL HOSPITAL WINAMAC IN 46996	6	33	8-74	2	100	6-94	10	10	1-47	.	.		55	5	1-15	11	0	0-49	3	0	0-100	29	3	1-21	24	0	0-38			
PUTNAM CO HOSP GREENCASTLE IN 46135	11	18	9-62	3	67	10-92	25	12	3-30	4	0	0-100	79	3	1-12	30	0	1-23	3	0	0-100	48	4	2-17	27	0	0-26			
RANDOLPH COUNTY HOSPITAL WINCHESTER IN 47394	5	20	1-71	5	40	11-82	7	0	1-57	2	0	0-100	25	4	0-24	2	0	0-93	3	0	0-100	11	9	0-44	21	0	0-37			
REID MEMORIAL HOSPITAL INC RICHMOND IN 47374	19	32	8-52	16	25	13-59	97	5	4-17	19	0	0-94	265	5	2-9	139	3	1-11	21	0	0-92	172	5	2-9	152	1	0-6			
RICHMOND STATE HOSPITAL QE RICHMOND IN 47374													1	0	0-100	.														
RIVERVIEW HOSP NOBLESVILLE IN 46060	11	18	3-54	7	14	11-73	31	13	3-28	2	0	0-100	108	5	2-12	33	0	0-22	9	0	0-100	89	4	2-13	53	2	0-14			
RUSH MEM HOSP RUSHVILLE IN 46173	4	50	8-84	4	25	9-85	7	0	1-57	.	.		53	6	1-16	18	0	0-33	1	0	0-100	25	0	1-25	11	0	0-71			
SCOTT COUNTY MEMORIAL HOSP SCOTTSBURG IN 47170	11	9	6-58	1	0	2-98	8	25	0-54	.	.		51	0	1-16	16	6	1-35	2	0	0-100	43	7	1-17	18	0	0-69			
ST ANTHONY HOSP MICHIGAN CITY IN 46360	9	22	2-57	14	21	14-62	26	0	1-26	.	.		161	10	3-12	57	2	1-16	7	0	0-100	71	1	1-12	74	0	0-11			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																													
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease											
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent								
ST ANTHONY MEDICAL CENTER CROWN POINT IN 46307	IN-89	1801	11	8-14	110	24	15-34	60	25	18-42	22	23	8-43	86	26	15-33	63	37	26-51	36	31	12-42	121	21	13-29								
ST CATHERINE HOSP OF EAST EAST CHICAGO IN 46312	IN-90	1613	12	8-15	132	37	20-39	66	21	14-36	34	18	9-38	104	17	14-31	64	38	25-49	39	26	4-30	93	20	12-30								
ST ELIZABETH HOSP MED CENT LAFAYETTE IN 47904	IN-91	2247	13	10-16	203	33	19-36	84	25	19-40	56	18	8-31	101	23	16-33	86	34	28-50	63	22	11-35	181	19	11-25								
ST FRANCIS HOSPITAL CENTER BEECH GROVE IN 46107	IN-92	3696	13	9-16	274	26	18-33	145	31	20-36	107	22	11-30	179	27	16-30	120	44	29-48	111	17	9-29	336	22	15-26								
ST JOHNS HICKEY MEMORIAL H ANDERSON IN 46014	IN-93	2052	13	9-16	154	25	17-35	94	33	20-40	39	33	7-34	151	22	14-28	74	38	26-49	65	25	10-34	178	25	12-26								
ST JOSEPH HOSP AND HLTH CT KOKOMO IN 46901	IN-94	1578	17	9-16	128	40	14-33	52	33	16-41	42	24	9-36	124	27	15-31	46	54	25-53	51	14	8-32	122	24	12-29								
ST JOSEPH HOSP OF MISHAWAK MISHAWAKA IN 46544	IN-95	1076	12	9-16	66	23	10-32	34	32	17-48	20	15	8-45	68	16	14-35	57	30	25-51	26	23	9-43	94	14	12-30								
ST JOSEPH MEDICAL CENTER FORT WAYNE IN 46802	IN-96	2034	10	8-14	133	23	14-33	70	24	18-40	47	28	7-31	105	22	16-33	65	35	26-51	57	16	8-32	118	14	13-29								
ST JOSEPHS HOSP HUNTINGBURG IN 47542	IN-97	583	10	9-16	18	22	10-51	27	30	16-50	15	7	5-46	31	23	11-41	19	37	19-51	22	9	5-40	79	18	13-33								
ST JOSEPHS MEDICAL CENTER SOUTH BEND IN 46634	IN-98	3368	12	9-15	272	27	17-32	102	35	19-37	74	22	12-34	154	23	16-30	93	39	30-51	98	16	11-31	215	18	14-28								
ST MARGARET HOSP HAMMOND IN 46320	IN-99	2807	14	9-15	195	24	17-33	105	31	20-38	66	24	10-32	163	29	17-31	126	40	29-47	76	21	9-31	198	19	12-25								
ST MARY MEDICAL CENTER GARY IN 46402	IN-100	2329	12	8-15	128	30	16-35	100	28	18-37	79	19	8-28	158	19	16-30	68	49	26-50	68	13	8-30	182	22	12-25								
ST MARYS HOSP INC EVANSVILLE IN 47715	IN-101	2869	12	9-16	276	26	19-35	122	24	20-38	73	19	10-30	160	21	16-30	103	49	30-50	49	10	7-33	232	16	13-26								
ST VINCENT HOSPITAL AND HE INDIANAPOLIS IN 46207	IN-102	6332	11	8-14	489	33	20-34	150	21	19-35	119	21	10-27	251	22	17-29	210	37	28-44	96	14	11-31	319	21	15-27								
STARKE MEMORIAL HOSP KNOX IN 46534	IN-103*	452	12	7-15	13	62	10-57	19	11	10-48	9	0	1-52	34	29	12-40	14	64	18-66	14	21	5-48	51	18	9-31								
TERRE HAUTE REGIONAL HOSP TERRE HAUTE IN 47802	IN-104*	1344	11	9-16	123	31	19-38	43	26	16-44	13	23	6-51	67	24	14-35	60	40	29-54	34	12	10-41	97	18	12-30								
THE COMMUNITY HOSPITAL MUNSTER IN 46321	IN-105	1907	13	8-15	114	30	16-35	70	34	18-40	34	32	8-36	135	28	15-30	103	38	26-46	32	34	9-40	142	18	11-26								
THE KINDS DAUGHTERS HOSPIT MADISON IN 47250	IN-106	1509	14	10-17	72	29	15-38	77	18	17-38	24	8	6-38	112	29	15-32	77	57	27-50	65	5	8-30	207	22	13-26								
THE LUTHERAN HOSP OF FORT FORT WAYNE IN 46807	IN-107	3708	11	8-14	293	20	16-31	136	26	20-36	82	20	9-29	183	29	17-30	131	36	29-47	57	5	9-34	198	23	13-26								
THE METHODIST HOSPITAL OF GARY IN 46402	IN-108	1075	13	8-15	57	35	14-39	39	31	15-43	29	28	6-35	74	18	14-34	28	43	25-61	35	26	8-37	77	21	11-30								
TIPTON COUNTY MEMORIAL HOS TIPTON IN 46072	IN-109*	611	11	8-16	22	27	8-44	21	38	11-48	11	18	3-49	45	22	14-39	20	50	17-58	22	9	6-41	72	15	10-29								
UNION CITY MEMORIAL HOSPIT UNION CITY IN 47390	IN-110	159	11	8-20	2	100	5-93	11	9	9-60	4	25	1-74	9	11	4-55	6	83	12-79	13	15	3-47	30	7	7-36								
UNION HOSPITAL INC TERRE HAUTE IN 47801	IN-111	2961	14	9-16	240	27	17-33	130	38	20-37	52	27	10-34	184	27	16-29	129	41	30-49	67	22	9-32	258	17	12-24								
UNIVERSITY HEIGHTS HOSP INDIANAPOLIS IN 46227	IN-112	803	12	8-16	54	20	14-39	24	33	13-48	18	17	2-37	44	25	13-38	26	42	21-58	21	19	4-39	82	23	11-30								
VERMILLION COUNTY HOSPITAL CLINTON IN 47842	IN-113*	619	17	11-20	25	48	12-47	41	29	14-41	23	35	6-39	42	26	13-39	49	41	28-56	23	17	6-40	73	18	11-31								
WABASH COUNTY HOSPITAL WABASH IN 46992	IN-114*	599	14	10-18	22	14	7-42	40	33	15-43	16	31	9-51	34	26	11-40	21	38	22-63	25	24	7-41	98	16	11-28								

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
ST ANTHONY MEDICAL CENTER CROWN POINT IN 46307	8	0	2-60	24	38	24-64	30	10	3-27	13	0	0-98	128	3	2-11	75	5	1-14	8	0	0-100	394	6	2-7	92	1	0-8			
ST CATHERINE HOSP OF EAST EAST CHICAGO IN 46312	11	27	6-58	5	60	12-83	15	13	1-36	17	0	0-92	176	6	2-10	76	4	1-14	15	7	0-92	215	4	2-8	86	0	0-9			
ST ELIZABETH HOSP MED CENT LAFAYETTE IN 47904	26	23	12-51	28	46	22-59	78	8	3-17	10	0	0-100	272	7	3-9	96	2	1-13	18	0	0-46	230	7	2-8	104	2	0-8			
ST FRANCIS HOSPITAL CENTER BEECH GROVE IN 46107	22	9	6-46	51	43	22-51	113	13	4-16	9	0	0-98	374	3	3-8	179	4	2-12	37	3	0-49	344	7	3-8	210	3	1-5			
ST JOHNS HICKEY MEMORIAL H ANDERSON IN 46014	21	5	6-47	16	25	16-62	69	12	4-20	4	0	0-100	250	4	3-10	114	2	1-12	29	0	0-87	134	4	2-9	120	3	0-7			
ST JOSEPH HOSP AND HLTH CT KOKOMO IN 46901	15	40	12-61	21	33	23-65	50	10	2-20	4	0	0-100	156	6	2-10	53	6	2-18	14	0	0-91	153	9	2-9	100	5	0-8			
ST JOSEPH HOSP OF MISHAWAK MISHAWAKA IN 46544	7	14	5-66	21	38	15-56	35	14	2-22	2	0	0-100	104	10	2-11	49	8	1-17	12	0	0-99	101	3	2-11	83	1	0-10			
ST JOSEPH MEDICAL CENTER FORT WAYNE IN 46802	24	21	11-51	18	39	15-58	54	7	2-19	15	13	0-95	209	4	2-8	69	3	1-15	9	0	0-96	274	4	3-8	132	2	0-7			
ST JOSEPHS HOSP HUNTINGBURG IN 47542	2	50	0-90	7	14	9-72	16	19	2-36	3	0	0-100	63	2	1-14	16	0	0-38	3	0	0-100	62	6	1-13	44	0	0-17			
ST JOSEPHS MEDICAL CENTER SOUTH BEND IN 46634	55	31	15-47	37	46	25-59	108	10	5-18	24	0	0-77	406	4	3-8	130	3	1-12	37	3	0-72	199	4	2-9	285	1	0-4			
ST MARGARET HOSP HAMMOND IN 46320	27	33	9-48	33	39	23-58	81	11	3-17	28	0	0-82	271	9	3-9	131	8	2-12	28	0	0-45	203	4	2-9	134	2	0-6			
ST MARY MEDICAL CENTER GARY IN 46402	31	26	8-45	25	16	19-57	52	17	3-20	3	0	0-100	241	6	3-9	80	4	1-14	5	0	0-100	231	3	2-8	156	0	0-6			
ST MARYS HOSP INC EVANSVILLE IN 47715	39	23	10-45	24	21	17-56	66	9	5-22	29	0	0-68	229	7	3-10	122	2	1-12	37	0	0-41	245	4	2-8	247	1	0-5			
ST VINCENT HOSPITAL AND HE INDIANAPOLIS IN 46207	53	26	15-47	72	43	25-51	167	8	4-14	126	0	0-8	401	8	3-8	211	3	2-11	38	0	0-43	1216	6	3-6	492	0	0-3			
STARKE MEMORIAL HOSP KNOX IN 46534	5	40	4-74	4	50	5-79	11	18	1-44	1	0	0-100	63	2	1-14	26	4	0-25	3	0	0-100	36	8	0-18	31	3	0-27			
TERRE HAUTE REGIONAL HOSP TERRE HAUTE IN 47802	7	29	2-63	5	40	7-76	37	11	3-24	4	0	0-100	130	3	2-10	30	0	0-23	13	0	0-65	183	4	2-9	80	1	0-9			
THE COMMUNITY HOSPITAL MUNSTER IN 46321	16	38	9-55	7	71	14-77	34	9	2-24	1	0	0-99	239	3	2-8	112	1	1-12	30	0	0-93	177	4	2-9	107	4	0-7			
THE KINGS DAUGHTERS HOSPIT MADISON IN 47250	14	43	8-56	17	41	17-62	31	6	2-24	1	0	0-100	162	3	3-12	65	9	1-15	10	0	0-99	130	4	2-9	64	0	0-11			
THE LUTHERAN HOSP OF FORT FORT WAYNE IN 46807	67	13	12-42	20	15	15-56	123	10	4-15	35	0	0-32	290	7	3-9	118	4	1-12	40	0	0-62	489	5	3-7	398	1	0-4			
THE METHODIST HOSPITAL OF GARY IN 46402	13	23	7-57	5	60	7-77	11	0	1-44	3	0	0-100	61	8	2-15	57	9	2-18	6	0	0-100	115	3	2-10	34	0	0-27			
TIPTON COUNTY MEMORIAL HOS TIPTON IN 46072	5	0	3-72	5	80	14-85	13	0	1-40	.	.	.	86	6	1-12	15	7	0-37	8	13	0-100	70	1	1-12	20	0	0-47			
UNION CITY MEMORIAL HOSPIT UNION CITY IN 47390	1	0	0-97	2	0	2-90	2	0	0-98				6	0	0-76	6	0	0-68	3	0	0-100	12	0	0-45	1	0	0-100			
UNION HOSPITAL INC TERRE HAUTE IN 47801	24	21	9-49	56	32	24-52	118	10	4-16	8	0	0-100	329	6	2-8	115	3	1-12	51	0	0-65	269	3	2-8	143	1	0-6			
UNIVERSITY HEIGHTS HOSP INDIANAPOLIS IN 46227	7	43	6-68	16	13	13-59	28	7	3-28	8	0	0-100	78	4	2-13	57	0	3-20	10	0	0-100	44	7	1-17	57	0	0-14			
VERMILLION COUNTY HOSPITAL CLINTON IN 47842	7	43	8-71	11	36	14-67	33	9	4-28				58	3	2-15	23	17	2-29	6	0	0-100	38	0	1-18	17	0	0-39			
WABASH COUNTY HOSPITAL WABASH IN 46992	15	7	9-56	4	0	11-86	30	10	2-25				83	6	2-13	5	20	0-70	6	0	0-100	33	3	1-20	15	0	0-48			

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WARRICK HOSPITAL INC BOONVILLE IN 47601	IN-115	314	15	10-20	9	22	10-66	18	17	13-53	6	17	5-68	19	47	10-49	14	36	18-66	12	0	2-47	29	28	11-42
WASH CO MEM HOSP SALEM IN 47167	IN-116*	393	17	10-19	15	47	8-51	29	31	16-49	5	20	1-68	24	29	11-45	25	44	23-61	9	22	3-54	65	18	12-33
WELBORN MEMORIAL BAPTIST H EVANSVILLE IN 47713	IN-117	2180	11	7-14	210	14	14-30	69	35	18-40	40	23	7-33	81	17	13-32	86	41	26-47	70	16	9-32	126	21	10-26
WELLS COMMUNITY HOSPITAL BLUFFTON IN 46714	IN-118	405	12	10-19	37	27	13-43	22	36	14-51	15	13	8-51	31	13	12-42	18	33	19-62	8	0	3-57	37	24	11-39
WESTVIEW HOSPITAL INDIANAPOLIS IN 46222	IN-119	641	10	8-15	31	35	14-47	12	17	10-58	8	25	1-55	41	24	12-38	11	27	17-70	18	11	7-46	64	14	10-31
WHITE CO MEMORIAL HOSP MONTICELLO IN 47960	IN-120	477	15	9-17	14	36	9-54	19	37	14-54	11	9	3-50	24	29	9-43	22	45	22-61	12	8	4-49	74	19	11-31
WHITLEY COUNTY MEMORIAL HO COLUMBIA CITY IN 46725	IN-121*	635	13	9-17	35	43	10-39	25	24	16-52	20	20	7-44	46	22	13-38	24	33	20-58	8	0	2-56	88	15	11-29
WILLAIM N WISHARD MEMORIAL INDIANAPOLIS IN 46202	IN-122	1643	11	7-14	88	26	16-37	57	26	16-40	31	26	5-34	82	12	12-31	48	44	25-53	52	8	6-30	193	17	11-25
WILLIAM S MAJOR HOSPITAL SHELBYVILLE IN 46176	IN-123*	737	14	9-17	28	21	10-43	34	24	16-46	24	21	7-39	48	19	13-38	25	40	20-57	36	11	6-34	106	23	13-30
WINDNA MEMORIAL HOSPITAL INDIANAPOLIS IN 46208	IN-124*	1969	12	8-15	140	26	14-32	59	20	17-40	42	14	8-34	107	25	14-31	57	33	27-53	41	20	10-38	195	15	11-24
WIRTH OSTEOPATHIC HOSPITAL OAKLAND CITY IN 47660	IN-125	151	18	9-21	3	33	3-84	4	50	6-80	1	100	2-99	10	30	7-58	3	33	4-84	12	0	2-46	27	19	8-39
WITHAM MEMDRIAL HOSPITAL LEBANON IN 46052	IN-126*	651	12	10-18	24	25	11-47	27	26	14-48	13	38	6-50	42	19	14-41	26	38	24-61	29	10	5-35	75	20	12-32
WOODLAWN HOSPITAL ROCHESTER IN 46975	IN-127*	466	14	9-17	20	30	8-46	17	29	12-53	14	29	4-45	42	26	11-36	16	56	18-63	16	13	4-43	55	15	11-33
JACKSON CO SCHNECK MEM HDS SEYMOUR IN 47274	IN-128*	858	15	10-17	41	29	12-40	40	15	18-47	11	27	5-54	64	30	14-36	31	58	24-58	20	5	6-42	90	26	14-33

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WARRICK HOSPITAL INC BOONVILLE IN 47601	6	17	3-68	6	50	10-76	4	25	0-75				29	3	1-22	22	9	1-29	5	0	0-100	31	0	1-22	4	0	0-99
WASH CO MEM HOSP SALEM IN 47167	9	56	5-61	.	.		15	0	1-37	.	.		43	5	1-16	20	5	1-30	1	0	0-100	52	4	1-15	11	0	0-80
WELBORN MEMORIAL BAPTIST H EVANSVILLE IN 47713	27	19	7-44	23	39	18-58	61	16	3-18	18	0	0-96	200	7	2-9	133	2	1-11	37	0	0-70	207	7	2-8	114	1	0-7
WELLS COMMUNITY HOSPITAL BLUFFTON IN 46714	3	67	7-89	5	40	9-79	23	9	3-32	.	.		49	2	1-16	21	0	0-30	8	0	0-100	21	0	1-28	13	0	0-43
WESTVIEW HOSPITAL INDIANAPOLIS IN 46222	10	30	11-67	16	44	19-65	20	0	1-31	1	0	0-100	60	7	1-15	27	7	1-25	7	0	0-100	48	0	1-16	73	0	0-10
WHITE CO MEMORIAL HOSP MONTICELLO IN 47960	7	14	8-71	3	33	4-84	10	0	1-47	1	0	0-100	49	4	1-15	19	0	0-33	6	0	0-100	45	13	1-17	19	5	0-41
WHITLEY COUNTY MEMORIAL HO COLUMBIA CITY IN 46725	8	38	10-70	5	20	7-77	15	0	1-36	.	.		85	4	2-14	26	4	1-25	8	0	0-100	40	8	1-18	23	4	0-38
WILLAIM N WISHARD MEMORIAL INDIANAPOLIS IN 46202	20	15	6-48	7	14	10-73	44	14	2-20	78	1	0-19	88	9	3-14	93	10	2-14	14	0	0-97	88	8	1-11	70	1	0-12
WILLIAM S MAJOR HOSPITAL SHELBYVILLE IN 46176	7	14	6-68	6	17	9-75	14	21	1-38	.			63	2	1-14	38	8	1-20	4	0	0-100	59	3	1-14	30	0	0-26
WINONA MEMORIAL HOSPITAL INDIANAPOLIS IN 46208	17	29	6-50	31	55	21-57	39	21	2-22	15	0	0-96	197	7	2-9	122	6	2-13	14	0	0-81	153	5	2-9	93	2	0-8
WIRTH OSTEOPATHIC HOSPITAL OAKLAND CITY IN 47660	10	40	8-63	4	50	10-86	.	.					21	10	1-28	5	0	0-73	.	.		8	0	0-62	7	14	0-82
WITHAM MEMORIAL HOSPITAL LEBANON IN 46052	7	43	5-67	18	50	21-66	25	0	1-27	2	0	0-100	80	5	2-13	26	0	2-28	8	0	0-100	58	2	1-15	22	0	0-35
WOODLAWN HOSPITAL ROCHESTER IN 46975	8	13	2-60	6	17	10-77	9	0	0-53	.			59	5	2-15	27	4	1-25	4	0	0-100	46	2	1-16	8	0	0-93
JACKSON CO SCHNECK MEM HOS SEYMOUR IN 47274	15	53	16-66	20	40	17-59	19	0	2-33	1	0	0-100	136	5	2-10	50	6	1-17	8	0	0-99	64	3	2-14	51	0	0-15

*Written Comments Not Submitted.

ADAMS COUNTY MEMORIAL HOSPITAL

805 High St., Decatur, Indiana 46733 (219) 724-2145

"Professionally We Serve, Personally We Care"

ANDREW J. BARRETT, II
Executive Director

October 23, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
6325 Security Blvd.
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

This letter is the official response of Adams County Memorial Hospital to the Health Care Financing Administration (HCFA) release of selected mortality information for our hospital. My analysis of the data indicates that Adams County Memorial Hospital does not have mortality rates in excess of your predicted mortality rates for patients treated in 1986. While this is certainly gratifying and allows me to breathe a sigh of relief, I am not sure what else these data say to our community, hospital trustees, or medical staff. Without specific knowledge of the model used to develope the predicted rates of mortality, the data are essentially meaningless to health professionals and potentially misleading to the public.

As a hospital with very positive outcomes it is tempting to engage in self-promotion relative to hospitals whose results are less optimal. But as Carol McCathy, President of the American Hospital Association, stated at the Indiana Hospital Association Annual Meeting, "These data say absolutely nothing definitively about the quality of health care".

Our hospital has several characteristics that could easily result in higher than expected mortality rates if not accounted for in a study such as this. The fact that we operate a very high level, skilled, Paramedic Ambulance Service could result in patients with marginal chances of survival being successfully brought to and admitted to our hospital only to subsequently expire after admission. The fact that we staff our emergency department with physicians on a virtual full-time basis exposes us to the same type of outcome. Our initiation of an Oncology Treatment Program could account for an increased exposure to admitting terminal cancer patients, increasing our risk of "failing" your test.

To my knowledge the model used by your study does not account for any of these characteristics on other than a gross basis. While they would potentially contribute to an increased mortality rate and to increased risk of exceeding your expected rates, they very obviously contribute to imporved quality of life for the residents of Adams County, Indiana.

Despite the nature of your study, our hospital will remain committed to providing high quality, accessible, comprehensive health services to our patients. Even if it may mean exceeding your criteria in the future.

Very truly yours,

ADAMS COUNTY MEMORIAL HOSPITAL

Andrew J. Barrett, II
Executive Director

AJB/als

cc: Board of Trustees
Indiana Hospital Association
American Hospital Association

October 14, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

This letter is in response to your plan to publish hospital specific mortality data.

Although none of Ball Memorial Hospital's actual mortality rates fell outside of your range of predicted mortality rates, I am writing to express our concern regarding your methodology to quantify quality. Among our concerns are the following:

1) The published mortality rates lead one to believe the cause of death is a result of illness in the diagnostic category listed, when in fact, the diagnostic category listed is the principal diagnosis, and may not be the cause of death.

2) The actual mortality rates are not statistically valid for the low volume of cases in some categories.

3) The severity of illness of hospitals was not considered when predicting mortality. In reality, referral institutions like Ball Memorial can expect to treat a large number of "sicker" patients resulting in higher mortality rates.

4) The mix of services for a hospital was not factored. Because we have an inpatient oncology program, a radiation therapy program, a hospice program, numerous intensive care units, an open heart surgery program, two catheterization labs, an angioplasty program, and other specialty services we should expect our mortality rate to be higher than hospitals not offering similar services. These facts, however, were not considered when computing your data.

BALL MEMORIAL HOSPITAL, INC.
2401 University Ave. • Muncie, IN 47303-3499 • (317) 747-3111
Member of the Voluntary Hospitals of America System.

5) By measuring death within 30 days of admission you may be including causes totally unrelated to the hospitalization.

While I commend you on your effort to quantify mortality, I believe you do the health care industry an injustice by implying to consumers that quality can be inferred by the methodology you have employed and plan to publish. It is my hope that you will rethink your strategy until a more valid method can be utilized that will provide more meaningful data to the citizens of our country.

Sincerely,

Greg

Greg Carlson
Vice President/Operations

/mcm

cc: Robert T. Brodhead, President/CEO, BMH
Carol McCarthy, President AHA
Ken Stella, President IHA

(812) 279-3581

Bedford Medical Center
HOSPITAL AND HEALTH CARE CENTER

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

This letter is in response to published mortality statistics for Bedford Medical Center, Bedford, Indiana, Hospital #15-0124. In your diagnostic category of cancer, we were found to have an actual mortality rate of 42%, with a predicted range of 13-41%. After reviewing all 18 charts, we found that two charts had sequencing errors, therefore, placing Bedford Medical Center within the range of predicted mortality rates (37%). (See enclosed detailed review of these charts.)

The majority of the physicians on the staff of Bedford Medical Center are specialists of one type or another, therefore we tend to get a large number of referral cases and tend to treat patients who are more critically ill than the average. We feel that one of the drawbacks of a study of this type is the lack of a meaningful method to accurately categorize severity of illness. As you, yourself, have stated, there is no means at the present time to accurately categorize severity of illness, therefore it tends to penalize those institutions who are taking care of the most severely ill patients.

For years we have carried out a very extensive quality assurance program at Bedford Medical Center. Every patient chart is screened according to carefully selected criteria, and any chart that falls out is reviewed by the appropriate department of the medical staff at their monthly meetings. There is constant communication back and forth between these departments and the individual medical staff members. This procedure, of course, is carefully scrutinized by the Joint Commission on Accreditation, and we have always received full accreditation from this review body.

2900 W. SIXTEENTH ST. · BEDFORD, INDIANA 47421

Overall, this committee feels our hospital has benefited from this study and will continue an on-going mortality review for quality of care in various diagnostic categories. Furthermore, we plan to classify our patients with cardio-vascular disease by anatomy, pathology and classification grade I thru IV, thereby, helping medical records personnel to differentiate acute from chronic cardio-vascular disease.

Sincerely,

Dan Berg, MD

Dan Berg, M.D., Chairman
Utilization Review Committee

DB:ke

(812) 279-3581

Bedford Medical Center
HOSPITAL AND HEALTH CARE CENTER

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Enclosed you will find information from two charts which our hospital Utilization Review Committee felt were sequenced incorrectly and do not belong under the cancer category.

Patient ID# - [redacted]
Patient Name - [redacted]
Admission Date - [redacted]
Discharge Date - [redacted] (Death)
Primary Diagnosis - 162.0
Primary Procedure - 332.2

59 year old white male, history of laryngeal cancer and status post two years laryngectomy with permanent tracheostomy undergoing chemotherapy and radiation therapy now with onset of bleeding from tracheostomy site, orthostatic hypotension and anemia. The patient was admitted, given 5 units packed red blood cells, initial hemoglobin was 9.2, also surgical consultation was obtained. The patient expired on 3/28/86. After study, the reason for this hospital admission was due to bleeding from the tracheostomy site, orthostatic hypotension and anemia. The cancer of the larynx was diagnosed two years ago. Therefore, the primary diagnosis should be: hemorrhage from a permanently implanted surgical device (tracheostomy).

Patient ID# - [redacted]
Patient Name - [redacted]
Admission Date - [redacted]
Discharge Date - [redacted]
Primary Diagnosis - 199.1

2900 W. SIXTEENTH ST. · BEDFORD, INDIANA 47421

72 year old white male, history of metastatic cancer of colon. Presenting with hypotension and CHF. Initially treated in emergency department with IV Lasix and Dopamine, then admitted to ICU; ABG 5, hypoxemia, and patient had gradual downhill course and expired.

After study, the reason for admission and the treatment was aimed at CHF and hypotension - patient initially treated in emergency department with Lasix and Dopamine. Therefore, Primary Diagnosis should be CHF 428.0; Secondary Diagnosis - Hypotension; Third Diagnosis - History of Colon Cancer

Removing these two charts from the cancer category would give Bedford Medical Center a 37% predicted mortality percentage, which would be in the range of 13-41%.

Sincerely,

Dan Berg, MD
ke

Dan Berg, M.D., Chairman
Utilization Review Committee

DB:ke

Clark County
Memorial Hospital

Merle E. Stepp
Executive Director

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

RE: Provider No. 15-0009

After reviewing your recently received mortality data, I would like to point out some factors which I feel cause the figures to be somewhat misleading.

First, our hospital is a large hospital which is surrounded by several small rural hospitals. When these institutions have patients in poor condition, they often transfer them to us, as they do not have the facilities to provide optimal diagnosis and care. No data points out the fact that these patients have been transferred from other institutions due to the severity of their condition.

Also, the severity of patients' illnesses is not taken into consideration in figuring the data. The data is based only on the principal diagnosis, not the cause of death. This makes it possible, for example, that a patient could have been discharged in a low risk category such as benign prostatic hypertrophy, and then three days after discharge suffer an acute, massive myocardial infarction, and expire before reaching the hospital; however, your data sheet would show that person's death to be attributed to benign prostatic hypertrophy.

If you are going to study hospital mortality, let's base the data only on patients in the hospital, for a true and accurate study for release to the public. Of sixteen categories listed by surnames and ID numbers, forty of the patients had been discharged from the hospital when death occurred.

One error I want specifically to note is regarding ID # [redacted] diagnostic category HL, age 68, female, admitted [redacted] and expired [redacted] You show the principal diagnosis to be 427.69 (arrhythmia) when the cause of death documented and attested to in the medical record is 410.1 (acute myocardial infarction).

Finally, there is no way to assess cause of death errors in your seventeenth category (all other causes), as there is no listing given, and no way to determine if there may be additional errors here.

Our hospital's Quality Assurance Department and an ad hoc committee comprised of medical staff members review all mortalities within the hospital, regarding the quality and appropriateness of care. We give the highest quality of care possible, evidenced by the facts that we have been given a three year accreditation by the Joint Commission on Accreditation of Healthcare Organizations and are surveyed yearly by the Indiana State Board of Health. I would like to be able to feel confident that data being released for public review reflects this quality of care by being figured as accurately as possible, taking into account all available facts and not just selected portions.

Sincerely,

Merle E. Stepp

Merle E. Stepp
Executive Director

MES:nld

Phone (812) 448-2675

CLAY COUNTY HOSPITAL

1206 EAST NATIONAL AVENUE BRAZIL, INDIANA 47834

October 22, 1987

Dear Dr. Ropper:

Clay County Hospital is a 77 bed general, acute care facility located in Central Southwest Indiana. The hospital serves approximately 26,000 residents. The average age of our Medicare patients is 77 years of age. The hospital has continued to update the medical facility and most recently has added minimal and respite care programs for the local residents.

We feel that the Mortality Data Release for the calendar year of 1986 is a step in the right direction in compiling this type of information; however, it is important to realize that this information cannot be viewed as a measure of the quality of care a hospital is rendering, nor can it be a comparison of one hospital to another.

Clay County Hospital is continually looking at and evaluating care being rendered on a continuous basis by it's in-house Quality Assurance Committee, who in turn, reports it's findings on mortality as well as other quality indicators to the Medical Staff and Board of Directors. The inhouse Quality Assurance Committee has used the Mortality Data information as a tool to evaluate trends and to augment their own studies.

The hospital's Medical Staff, Board of Directors, and Administrators are comfortable with the finding that ranks us will within the predicted mortality range for our hospital at that time, but will continue, through internal review, to look at ways to improve the delivery of quality health care to the county we serve.

Sincerely,

Administrator

Chief of Staff

President of the Board

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

October 26, 1987

William L. Roper, M. D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

These comments are written to express the opinion of Clinton County Hospital regarding the HCFA mortality rates for 1986. We would first of all like to express our support for the public release of information, concerning health care institutions, that truly reflects quality of care. As seen in the released mortality statistics, for Clinton County Hospital, all categories fall within the range of predicted mortality rates, which is a favorable reflection. However, we still do have some serious concerns regarding the mortality data that is being given to the public because we believe it can mislead the public for the following reasons:

1.) Limiting deaths into 16 broad categories obscures medical conditions.

2.) Reporting deaths under principle diagnosis (i.e. DRGs) often obscures the exact cause of death.

3.) Factors contributing to death after hospitalization are not under the direct control of the hospital.

4.) The data does not adequately reflect the severity of illness or age of the beneficiary.

5.) The smaller the number of hospital admissions, the less reliable the mortality rate is as an accurate indicator.

6.) And, as HCFA reports in its Federal Register, "the model remains simply one indicator of 'potential' quality distinctions among hospitals."

With the above concerns, the Clinton County Hospital Utilization Review Committee reviewed certain specific details of the HCFA report with the conclusion that when the stated mortality rates stand alone, they cannot be considered as an accurate distinction of quality of care.

1300 SOUTH JACKSON / FRANKFORT, INDIANA 46041 / PHONE (317) 659-4731

For example, in the category of Severe Chronic Heart Disease, there were 45 cases noted with 33% mortality, which does fall within the acceptable range of 15 - 41%. What this does not show is that the average age of death in this category was 83 years old. And the category of Metabolic/Electrolyte Disturbances, the mortality rate is 43%, also in the predictable range of 11 - 57%. Five of the 6 deaths in this category were admitted to the hospital because of dehydration; however, the actual cause of death was terminal end-stage cancer. This again, cannot be known by just looking at the stated mortality rate. And, in the category such as Renal Disease where there are only 5 cases involved, the results can hardly be considered as an accurate measure of mortality.

It is important that the public realize the limitations of these statistics alone and also realize that the Clinton County Hospital has and always will hold a high standard for quality of care. All deaths are reviewed in detail by physicians on the mortality review committee, and to insure quality of care, we have active programs of quality assurance and infection control and continual reviews and interventions by tissue committee, pharmacy and therapeutics and patient care committees. No mortality statistic alone can reflect the work that is done on a daily basis to insure that each patient who seeks health care at Clinton County Hospital will be assured of continued high quality care.

We trust that these comments will be helpful so that such data disclosure does not provoke unnessary apprehension.

Sincerely,

Brian R. Zeh (u)

Brian R. Zeh
Executive Director

Enc:

COMMUNITY HOSPITAL • 1515 NORTH MADISON AVENUE • ANDERSON, INDIANA 46012 • (317) 642-8011

October 26, 1987

Health Standards and Quality Bureau
Attn: Harvey Brook
6325 Security Boulevard
Meadows East Building, Room 2-D-2
Baltimore, Maryland 21207

Attention: Comments on HSQ-148-GNC

Community Hospital submits the following comments to HCFA in response to the August 17, 1987, Federal Register General Notice for Comment regarding the anticipated public release in December of the 1986 mortality rates for Medicare patients.

We have reviewed the data sent to us regarding those patients treated at our facility in 1986, and are pleased the report indicates our figures are well within predicted outcomes. We attribute this very positive report to a strong quality commitment at Community Hospital; however, we would take this opportunity to offer precautions regarding the implications and proper use of this data.

Mortality figures serve as one tool which we employ to assist us in assessing the overall performance of our staff. Therefore, our Medical Staff, along with appropriate clinical departments and utilization review staff, conduct an intensive review of every patient death at our facility. Your data will help in that endeavor.

However, an appropriate assessment of a hospital's performance is dependent upon many variables and requires a review of many quality indicators in addition to mortality figures. Patient transfers, surgical complications, adverse drug reactions, readmissions, in-hospital infections and accidents, among others, are routinely examined by our quality review committees.

Also, the data does not take into account the severity of illness and other patient and hospital characteristics that may have a very heavy influence on mortality. And, in the limited amount of time we have had to validate the volume of data, we have found several errors which we will, due to confidentiality concerns, forward to your staff under separate cover.

For these reasons, we are most concerned that the general public be made aware that the mortality figures cannot be compared with other facilities as an independent quality measurement, but can best be used by each Hospital to better focus quality assessment activities. Under no circumstances should they be used as the basis for judging the quality of care provided by different hospitals.

Thank you for the opportunity to respond.

Sincerely,

R. Joe Johnston
Acting President

Roberta Allen
Roberta Allen, R.N.
Quality Assurance Coordinator

Community Hospitals Indianapolis

Community Hospital Indianapolis

1500 North Ritter Avenue
Indianapolis, Indiana 46219
Telephone (317) 353-1411

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services

Dear Dr. Roper:

Per your directive, dated September 21, 1987, Community Hospitals Indianapolis hereby submits its comments on the 1986 Medicare Mortality information.

We appreciate the opportunity to review this data and comment.

Sincerely,

William E. Corley
President
Community Hospitals Indianapolis

Enclosure (1)

KAT/WEC/kjp

REVISED

Community Hospitals Indianapolis has as its primary goal, the provision of high quality medical care. Because of our commitment and concern, we have reviewed the Health Care Financing Administration's (HCFA) data on mortality rates and have found that we are within the normal ranges for all 16 diagnostic categories. In further analysis of the data, we have verified that the number of HCFA-reported deaths is accurate.

Community Hospitals Indianapolis has been a participating Medicare hospital since the inception of the Medicare program in 1966. Throughout the 21 years of HCFA-mandated peer review in the PSRO and PRO programs, we have never undergone intensified review of quality-related issues. Patient mortality is reviewed on an ongoing basis as part of the Hospital's Medical Staff Quality Assurance Program. If concerns are identified during this process, corrective actions are taken.

Community Hospitals Indianapolis feels it is of the utmost importance for the public to understand that there are numerous conditions and circumstances which contribute to patient mortality which are not necessarily the result of poor quality care. In addition, mortality rates by themselves do not measure quality.

The American Hospital Association and other organizations, including the Joint Commission on Accreditation of Hospitals, are investigating methods of evaluating hospital quality that rely on measures other than mortality rates. Community Hospitals Indianapolis looks forward to the results of these efforts.

Community Hospitals Indianapolis is a city-wide network of health services including two acute care hospitals - - Community Hospital Indianapolis, a 750-bed hospital at 16th Street and Ritter Avenue on the east side of Indianapolis, and Community Hospital North, a 250-bed hospital at 82nd and Shadeland Avenue on the northeastside in Castleton. As a full-service medical complex, Community Hospitals' major programs include cancer care, cardiovascular, diabetes, mental health and psychiatry as well as comprehensive physical rehabilitation, neurological services and a pain center.

Community Hospital of Bremen
"Our family caring for yours"

October 6, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We are responding to your lette of September 21, 1987 regarding the release of mortality information by HCFA for acute care Medicare patients.

Community Hospital of Bremen, Indiana
Medicare Provider Number: 15-0110
Medicare Swing Bed Provider Number: 15-U110

I would first wish to comment on hospital specific data we have received.

Besides serving our community as an acute care hospital, we are also a Swing Bed Provider, where Medicare patients utilize our hospital for long term skilled nursing services. This is according to the Omnibus Reconciliation Act of 1980, Section 904.

I wish to point out that of the eighteen patient deaths provided to us by HCFA, seven of these patients had died in our hospital as skilled nursing patients. They were not short term acute care patients, as the data should reflect.

As a result, total cases and actual mortality rate should be adjusted downward. For short term care, according to our calculations, there were 136 acute care cases with 11 deaths for a mortality rate of 8%. This compares to 143 cases, 18 deaths, and a mortality rate of 13% originally sent.

Secondly, I personally feel that the general purpose and methodology or HCFA's release of mortality rates has shortcomings. There appears to be a lack of detail as to how HCFA has attempted to control for hospital case mix, or how to take into account patient co-morbidities, what diagnostic codes fall into the 16

(continued)

411 South Whitlock St., Bremen, IN 46506 Phone: 219-546-2211

catagories, or how well the model works in terms of its own internal statistical validility.

Finally, I make reference to your letter of September 21, 1987 where you recognize the limitations of the data. While hospital and professional societies may be able to use the data with its current methodology and limitations, I question its release to the general public. As your letter stated, mortality rates on their own are not a complete measure of the quality of care. Unfortunately, the American Public will be wrapped up in the "sensationalism" of the release of mortality data. This data will be over-emphasized by the press and the public, when considering the overall quality of care provided in our hospitals.

I thank you for the opportunity to communicate my concern on these issues.

Sincerely,

Jerome J. Bozek

Jerome J. Bozek
Administrator

CHAPTER COMMUNITY HOSPITAL
1815 48TH
DES MOINES, IA.
50310 5152716000

3 BC/BS PROV. NO.	4 FEDERAL TAX NO.	7 MEDICARE NO.	8 MEDICAID NO.	9 AD. DIAG
601336	58-1523702	[redacted]	[redacted]	276.5

10 PATIENT'S LAST NAME [redacted] FIRST NAME [redacted] INITIAL [redacted] PATIENT'S ADDRESS [redacted] CITY [redacted] STATE IA ZIP 50047

11 BIRTH DATE	12 SEX	13 DATE	14 HR	15 TYPE	16 SRC	17	18	19 ADM.	20 D.H.	21 STAT	22 FROM	THROUGH	23	24 M-C/D	25 C-I-D	26 I-R-D	27
03-17-94	M	02-12-86	15	1				19	20		02-12-86	02-23-86	11				1

28 OCCURRENCE CD	DATE	29 CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

[redacted]
[redacted]
IA 50047

35 CONDITION CODES 36 OCCURRENCE CODES AND DATES 37 BLOOD PINTS 38 39 40 PUR'HS 41 REL'D 42 NOT'D 43 DED'L 44 SP PROG. 45 MED RECORD # [redacted]

46	47 VALUE CD	AMT	CD	AMT	CD	AMT	CD	AMT
	01	1890.00						

50 DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54 NON-COV	55	56
ROOM-BOARD/2BED : 189.00	120	11	2079.00			
IV SOLUTIONS	258		1184.00			
LAB	300	39	1181.25			
DX X-RAY/CHEST	324		26.00			
ANESTHESIA	370		40.00			
EMEP ROOM	450		35.00			
RECOVERY ROOM	710		94.00			
EKG/ECG	730		35.00			
TOTAL CHARGES	001		8094.80			

PLEASE NOTE CORRECTED DIAGNOSIS CODES AND PROCCESS ACCORDINGLY.
THANK YOU!

57 PAYER	58 REL INFO	58 ASSIG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST AMOUNT DUE
A MEDICARE PART A	Y	Y	492.00				
B							
C							

DUE FROM PATIENT ▶

65 INSURED'S NAME	66 SEX	67 P REL	68 CERT-SSN-HIC ID NO	69 GROUP NAME	70 INSURANCE GROUP NO
A [redacted]	M	01	[redacted]		
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION
P		RETIRED		

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS
SEPTICEMIA NOS ;HYPOVOLEMIA

77 PRIN CODE	78 OTHER DIAGNOSES CODES			
276.5	038.9	427.5	599.0	332.0

82 PC 83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS

84 PRINCIPAL PROCEDURE CD	DATE	85 PR. PROCEDURE CD	DATE	86 OTHER PROCEDURE CD	DATE	87 OTHER PROCEDURE CD	DATE
57.21	02 17						

9 #

PRO-VIDER DATA

87 CD	88 APP FROM	89 APP THROUGH	90 GRC	91 TREATMENT AUTH.	92 ATTENDING PHYSICIAN ID.	93 OTHER PHYSICIAN ID.
5					009522 Dr. Bast	009522 Dr. Bast

94 REMARKS

LOGGED

VERIFIED HC STAY DATES FOR INTERMEDIARY USE ONLY

FROM	THROUGH	PR. PROC D			
A	B	C	D	E	
AMT REIMBURSED	REASON CD		APPROV BY	DATE APPROV	
F	G	H	J	K	

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Form 3916/3

IN 25.2 VIDER SIGNATURE X [signature] DATE 03 11 86 7-1-86

AMI Culver Union Hospital

October 22, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to provide comment on the mortality information the Health Care Financing Administration (HCFA) will be publishing regarding AMI Culver Union Hospital. The following is to be attached to our hospital's specific report prior to public disclosure.

AMI Culver Union is a 120 bed acute care center fully accredited by the Joint Commission on Accreditation of Health Care Organizations. Our case mix includes many patients with major medical and surgical illnesses. We are a full service health care center offering specialty areas in oncology, cardiac rehabilitation, and psychological counseling as well as general medicine and surgery.

The hospital and medical staff conduct ongoing review of the medical record of each patient who expires at this facility for appropriate medical management and overall quality of care. Mortality review is an important part of our quality assurance program. Peer review activities are an integral part of monitoring the health care delivery system of AMI Culver Union.

Our hospital's specific mortality data, as reported by HCFA, for Medicare patients in 1986 has been carefully reviewed by: Administration, Medical Staff, Director of Medical Records, and the Director of Community Relations. All of our actual mortality rates for the diagnostic categories are within the range of predicted mortality rates according to HCFA's analysis.

The Director of Medical Records has validated that, with minor exceptions, the data compiled by HCFA is accurate. This information indicates that a total of 105 Medicare patients admitted to AMI Culver Union Hospital expired within thirty days of admission. Of these, 76 expired while a patient in the hospital, and 29 apparently died after discharge. We have no way of validating post-discharge deaths. Our records cite 1,348 Medicare admissions occurring in 1986 as compared to 854 cases reported in the HCFA data. Presumably, this discrepency is due to the fact that HCFA includes only the last admission of patients admitted more than once during the year. In addition, the HCFA data contained one incorrect date of patient discharge, and two instances where the patient's date of discharge and date of expiration were identical. However, our records indicate these patients were discharged alive.

1710 Lafayette Road [illegible]

CULVER UNION
HOSPITAL

We at Culver Union Hospital fully support health care consumer education. However, we emphasize that the HCFA mortality data are not, in themselves, measures of hospital performance. Under no circumstances should they be used as the basis for judging the quality of care provided by hospitals.

Sincerely,

Michael L. Collins, F.A.C.H.E.
Executive Director

S.R. Marri, M.D.
Chief of Staff

CC: Rita McBride, M.Ed., RRA

DEACONESS HOSPITAL

October 22, 1987

Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Administrator:

In response to your letter of September 21, 1987, we have reviewed your data relating to Medicare Mortality in this hospital for the year of 1986.

We are enclosing our comments for publication with release of the data.

Additionally, we have detected discrepancies both in the number of admissions by diagnostic category as well as discrepancies in the reported number of deaths. To facilitate a review of these discrepancies we are providing you a complete listing of patients and deaths by diagnostic category as indicated by this hospital.

Sincerely,

Thomas H. Kramer

Thomas H. Kramer
President

THK:dp

Enclosure

COMMENTS ON HCFA MORTALITY DATA

DEACONESS HOSPITAL
Evansville, Indiana

A verification of the Medicare Mortality data used by the Health Care Finance Administration indicates that a total of 2,769 patients were identified as having a principal diagnosis falling within the sixteen (16) diagnostic categories. A review of our records indicates a total of 3,888 patients with a principal diagnosis within these categories. (Total was adjusted for your exclusion of patients with multiple admissions.)

HCFA data reflects 407 patients admitted to Deaconess Hospital died within 30 days of admission. Of these, 313 died while still patients of the hospital, while 94 died after discharge. Our records indicate that 441 patients died within 30 days of admission. Of these, 347 died while still patients of the hospital. We have no way of verifying the accuracy of your data regarding the post discharge deaths since we do not have access to Social Security data and choose not to contact family members with personal questions.

The effect of these discrepancies indicates that HCFA's mortality rate for this hospital is inflated, as shown in the following comparison:

DIAGNOSTIC CATEGORY	HCFA CASES	HOSP. CASES	HCFA MORTALITY RATE	HOSP. MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	4,073	4,590	12 %	11 %	8 TO 14 %
CA - CANCER	275	397	24 %	18 %	16 TO 31 %
CE - CEREBROVASCULAR ACCIDENTS	135	210	31 %	24 %	20 TO 37 %
EY - OPHTHALMOLOGIC DISEASE	53	70	2 %	1 %	0 TO 20 %
GC - GASTROINTESTINAL CATASTROPHIES	63	78	14 %	11 %	6 TO 27 %
GI - GASTROINTESTINAL DISEASE	381	505	6 %	5 %	3 TO 8 %
GU - UROLOGIC DISEASE	150	211	7 %	5 %	3 TO 13 %
GY - GYNECOLOGIC DISEASE	23	30	0 %	0 %	0 TO 82 %
HL - LOW-RISK HEART DISEASE	404	594	5 %	4 %	2 TO 7 %
HM - SEVERE CHRONIC HEART DISEASE	195	264	27 %	21 %	16 TO 29 %
HS - SEVERE ACUTE HEART DISEASE	143	216	42 %	30 %	29 TO 47 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	102	139	19 %	14 %	9 TO 29 %
OP - ORTHOPEDIC DISORDERS	303	398	1 %	1 %	0 TO 4 %
PN - PULMONARY DISEASE	321	441	19 %	15 %	13 TO 25 %
RN - RENAL DISEASE	34	55	32 %	22 %	12 TO 49 %
SE - SEPSIS	60	84	25 %	19 %	24 TO 52 %
TR - SEVERE TRAUMA	127	176	9 %	6 %	4 TO 15 %
Total of above -	2,769	3,888			

Although Deaconess Hospital's mortality rates are well within your ranges, it is our opinion that the statistical model you have used to measure mortality rates assumes that each hospital's patients are "average" except with the few characteristics included in the model. The model does not take the following into consideration:

- Severity (How ill was the patient at the time of admission?)
- Did the patient have a terminal illness?
- Many hospitals have an overall case mix that involves the treatment of more patients with acute or terminal conditions. Was this case-mix factor taken into consideration?
- Was the patient transferred to the hospital from a nursing home?
- Was the patient receiving treatment at home prior to admission?

We recognize and support the release of useful, reliable information to the public; however, mortality rates, by themselves, do not measure quality. Quality can only be evaluated through the process of peer review in conjunction with statistical comparisons.

Mortality review has long been considered part of the patient care evaluation process conducted by all hospitals. Clinical departments have for years held mortality/morbidity review on a case-by-case approach to distinguish those that were anticipated from those that were unexpected. In doing so, the medical staff can evaluate a series of critical questions to examine all aspects of the appropriateness of the care provided.

Only through this review methodology, and not through these abstract discussions of statistics, can mortality rates be properly evaluated.

Dearborn County Hospital

Office of the Executive Director

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Room 314G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Doctor Roper:

Thank you for the opportunity to respond to the mortality data supplied to us by the Health Care Financing Administration. We have carefully reviewed this information and feel it is necessary to make several comments. We understand that these comments will be a part of the public record.

It must first be pointed out that patient [redacted] is not dead. We have so notified Medicare and our peer review organization of that fact. Therefore, the total number of deaths you reported should be reduced to 155.

We take some satisfaction in having fallen **within** your ranges in **all categories.** However, we believe the whole program is so fundamentally flawed, few if any meaningful conclusions can be drawn. Some of our concerns are as follows:

1. Your model does not consider a variety of factors that you, as a physician, know can have a significant impact on mortality. These include a patient's general health status, severity and stages of illness, psychological considerations and a host of socio-economic factors.

2. Holding a hospital accountable for all deaths within 30 days of admission, but after discharge, seems patently unfair. Deaths within those 30 days could be related to something as obviously unrelated to a hospital stay as a traffic accident or to conditions that were not apparent prior to discharge or that developed after discharge.

600 WILSON CREEK ROAD • LAWRENCEBURG, INDIANA 47025
Telephone (812) 537-8200

3. The implication is that hospitals above the predicted norms are somehow at fault for the patient's death. This does not recognize the differences in patients or in treatments ordered by physicians.

4. It seems incomprehensible that if quality is what you are really after, that the patient's bill should be the source document rather than the patient's chart. As you know, people do die despite the best care and the financial record falls far short of addressing the issue of quality.

In closing, let me say that we seriously doubt that the quality of health care for Medicare patients will be affected in any positive way by the promulgation of this information. You have acknowledged the many shortcomings of this program. It seems to me that the shortcomings greatly exceed any legitimate benefits to be derived.

Sincerely,

Russell C. Dean, Jr.

Russell C. Dean, Jr.
Executive Director

cc: Representative Lee Hamilton
Senator Richard Lugar
Senator Dan Quayle

Decatur County Memorial Hospital
The care you want. Close by.

David V. Trexler
Executive Director

Telephone
(812) 663-4331

October 22, 1987

Dr. William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

The following information for Decatur County Memorial Hospital is to be attached to the specific report of the hospital's mortality statistics for 1986 prior to publication in December 1987.

Decatur County Memorial Hospital is a 115 bed, acute care, general medical facility. The hospital provides the community with a wide range of medical services including emergency care, acute and long term inpatient care, outpatient diagnostic services, home health care, maternity care and gynecology services, and general medical and surgical care.

The medical staff at Memorial conducts an intensive review of the medical record of each patient who expires at the hospital, to monitor medical management and overall care. Mortality review is an on-going process of the quality assurance program at Memorial.

Decatur County Memorial Hospital's specific mortality statistics have been reviewed by: the hospital Executive Director, Chief of Medical Staff, Director of Emergency Medicine, physician chairman of the Utilization Review and Medical Records Committee, Director of Utilization Review and Quality Assurance, Director of Laboratory, and Director of Medical Records.

Decatur County Memorial Hospital exists to improve the health of the community. Elderly patients often become ill and are admitted to the hospital for treatment. Many times the immediate illness is treated, but a medical decision is made, at the patient's and family's request and, in consultation with the attending physician, not to perform any heroic life prolonging

medical treatment in the event of a sudden medical crisis. The majority of deaths occurred in the 80 year old or older age group.

Sixty-three (63) of the eighty-two (82) deaths reported in the statistics were admitted with specific medical instructions not to perform ANY heroic life-prolonging measures. Of the patients with no such instructions, 98.5% were dismissed in good condition.

Many of the medicare patients reported were admitted more than once to the hospital. There were a total of 857 medicare admissions for 501 individuals and only 82 deaths. This reflects a somewhat lower 9.5% mortality rate for medicare admissions. Monitoring the quality of care at Decatur County Memorial Hospital will continue to be an intensely active process.

The hospital thanks the Health Care Financing Administration for the opportunity to present this response with the published data.

Sincerely,

DECATUR COUNTY MEMORIAL HOSPITAL

David V. Trexler
Executive Director

R. C. Domingo, M.D.
Chief of Staff

DeKalb Memorial
Hospital, Inc.

East Seventh Street
Auburn, Indiana 46706
(219) 925-4600

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to express our comments on the Health Care Financing Administration's Mortality data.

DeKalb Memorial Hospital is a 77 bed general acute-care facility, whose case mix includes surgical patients and acute medical illnesses. We also offer intensive care and oncology services.

Since receipt of the report on September 23, 1987 it has been carefully reviewed by hospital administration, the Utilization Review/Medical Records Committee of the Medical Staff, the Utilization Review Coordinator, and the Quality Assurance Coordinator. Attachment A indicates 3 data discrepancies noted from our report.

According to the HCFA report our actual mortality rates fall within the range of predicted mortality rates for all categories. It should be noted that 28% of the cases cited in our report were actually discharged alive. After physician review no apparent quality issue was noted, for all of the discharged patients were elderly, very sick, and death was not unexpected.

We view this study as just one component of our quality assurance activities. Mortality review is an on-going process of our Medical Staff. The HCFA data are not in themselves measures of hospital performance. We view them as a way to better focus our quality assurance activities.

Sincerely,

J. M. Corey

Jack M. Corey
President

ATTACHMENT A

HCFA MORTALITY DATA
DATA CHANGES

Three data discrepancies were noted in our report:

1. Patient ID #(HIC) [redacted] was discharged from DeKalb Memorial Hospital alive.

2. Patient ID #(HIC) [redacted] was discharged from DeKalb Memorial Hospital alive.

3. Patient ID #(HIC) [redacted] - Date of admission on our records indicates 12/26/86 and not 12/27/86.

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Resources
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to comment on the HCFA release of data concerning hospital mortality rates for the period of January 1 through December 31, 1986. We are pleased to see that Floyd Memorial Hospital's actual mortality rate in the category for All Causes is well within the probability ranges predicted by HCFA's statistical model.

We congratulate you on your organization's early efforts to develop predicted ranges of mortality rates. However, as you know, the method HCFA has devised to compute these ranges of probable mortality fails to consider many important factors that very often have a dramatic impact on the survival of an illness or injury.

Our Medical Records Department has found only minor errors in the data reported by HCFA. A team of clinical and administrative personnel have reviewed pertinent records and data.

We offer the following summary as information that HCFA or any interested member of the public should find useful in interpreting the data generated by the HCFA statistical model:

1. Floyd Memorial Hospital is a 270-bed acute care facility whose case mix includes many patients with major medical and surgical illnesses. We are one of only two hospitals in the Metropolitan Louisville area with an active, broadly-based Community Hospital Cancer Program fully certified and accredited by the American College of Surgeons Commission on Cancer. While we do have a high proportion of oncology and radiation therapy patients, we also offer a full range of care in specialty areas that include rehabilitative medicine, chemical dependency, major orthopedic care, as well as general medicine and surgery.

1850 State Street, New Albany, Indiana 47150 (812)944-7701

2. In those categories where the actual mortality rate exceeds the predicted range we have found factors in the individual cases that are not adequately considered by HCFA's statistical model. These include:

   A. The Metabolic/Electrolyte Disturbances category includes a very high proportion of terminal cancer patients.

   B. Because only nine patients were included in the Sepsis category we feel that the sample size is too small to be statistically valid. In addition, three patients in this category expired due to serious pre-existing medical conditions not related to sepsis. Please note that the average age of expired patients in this category is 81 years.

Finally, we would like to add that our hospital Medical Staff Committees monitor every death in our facility on an ongoing basis. We believe that our patient care evaluation systems provide us with continuous feedback that enables us to provide excellent medical care.

Again, thank you for this opportunity to provide information useful in interpreting the data generated by HCFA's statistical model.

Sincerely yours,

Sharon R. Schroder
Chairman
Board of Trustees

Charles B. Carty, M.D.
President
Medical Staff

John B. White
President
Floyd Memorial Hospital

GIBSON GENERAL HOSPITAL

Phone 385-3401 Area 812 1808 Sherman Drive
PRINCETON, INDIANA 47670

Affiliate Member of
Noram Enterprises, Inc.
Multi Hospital System

Office of the Administrator

October 22, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, MD 21207

RE: MORTALITY RATE 1986

Dear Doctor Roper:

This is in reference to your letter of September 21, 1987.

We are submitting comments on a diagnostic category of sepsis. Please refer to the highlighted item on the copy enclosed.

Our records show there were three Medicare cases of sepsis in 1986, and not two cases as shown on the report. Only two of these three cases resulted in death. This would give us an actual mortality rate of 66-2/3%, which would be within the range of predicted mortality rate.

If additional information is needed to correct this error, please feel free to contact us.

Sincerely,

GIBSON GENERAL HOSPITAL

William D. Gibson, FACHE
Administrator

WDG:mdr

xc - Joyce Carpenter,
Director of Medical Records

encl. (1)

DATA CORRECTIONS
DECATUR COUNTY HOSPITAL, LEON, IA 50144
PROVIDER NUMBER 16-0055

		PRINCIPAL DIAGNOSIS
[redacted]	H.C.F.A. Reported	428.1
	Should be	482.1
[redacted]	H.C.F.A. Reported	436
	Should be	V57.89

Good Samaritan Hospital
520 South Seventh Street
Vincennes, Indiana 47591
(812) 882-5220

October 9, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: Comments Regarding Mortality Information
Hospital ID Number - 150042

Dear Sir:

We have carefully reviewed the mortality information about Medicare patients treated at Good Samaritan Hospital in 1986. For the most part, we feel the data is accurate and well presented.

We found no instances where a patient was reported inaccurately as being an admission to our facility.

We did find one instance where an incorrect principal diagnosis was listed for a patient.

HIC #[redacted]- Your report indicated the principal diagnosis was 799.1 (respiratory failure), thus in the UN (All Other conditions) diagnostic category.

Our records indicated 428.0 (intractable congestive heart failure) was attested to by the attending physician as the principal diagnosis and submitted as such to the fiscal intermediary. We do show 799.1 as a secondary diagnosis. The principal diagnosis of 428.0 would place it in diagnostic category HM (severe chronic heart disease).

We are concerned about the data presented on your report regarding the patients who died after discharge. In each of the following cases, the patients died of a condition unrelated to what they were treated for in our facility.

We obtained this information from death certificates on file at our local City/County Health Department.

HIC # [redacted] - Your report and our records indicate the principal diagnosis for the hospitalization was 715.96 (osteoarthritis, left leg). The death certificate stated the patient died of a cardiac arrest and a pulmonary embolism.

HIC # [redacted] - Your report and our records indicate the principal diagnosis for the hospitalization was 451.0 (superficial phlebitis, leg). The death certificate stated the patient died of a cardiac arrest and congestive heart failure.

HIC # [redacted] - Your report and our records indicate the principal diagnosis for the hospitalization was 805.2 (fracture of the dorsal vertebra-closed). The death certificate stated the patient died of a cerebrovascular accident.

HIC # [redacted] - Your report and our records indicate the principal diagnosis for the hospitalization was 599.0 (urinary tract infection). The death certificate indicated the patient died of lung cancer.

HIC # [redacted] - Your report and our records indicate the principal diagnosis for the hospitalization was 573.3 (hepatitis). Information obtained from the nursing home where the patient later died indicated the reason for death as a stroke.

HIC # [redacted] - Your report and our records indicate the principal diagnosis for the hospitalization was 600.0 (hyperplasia, prostate). The death certificate indicated the patient died of congestive heart failure.

We feel this data on patients who died postdischarge is misleading as shown in the above-mentioned examples, and somewhat distorts the statistics for the various diagnostic categories.

We appreciate the opportunity given us to review data regarding our facility prior to its release to the public.

Sincerely,

A. John Hidde,
Executive Director

lal

Goshen General Hospital

COMMENTS ON THE HCFA MORTALITY DATA

Following extensive and intensive review of the HCFA mortality data, we feel that some points need to be corrected as they relate to the information HCFA supplied. Review of the data indicates there were 1,191 Medicare patients whose last admission in 1986 was at Goshen General Hospital. Of these 1,191 patients, 133 apparently died within thirty days of their last admission. Through our verification of the data, we learned that one patient was alive at the time of discharge and is still alive. Another patient who was shown as having died here could not be located as ever being a patient at Goshen General Hospital. It was also discovered that there were inaccuracies in some of the dates of death.

The overall actual mortality rate of 11% shows that Goshen General Hospital's mortality rate is within the "range of predicted mortality rates" as calculated by HCFA. It is noteworthy that Goshen General Hospital is below or within the "range of predicted mortality rates" in 15 of the 16 diagnostic categories.

The one diagnostic category in which Goshen General Hospital's actual mortality rate was shown beyond the "range of predicted mortality" is "Severe Acute Heart Disease." The figures provided by HCFA show there are 59 total cases in this diagnostic category of which 36 patients died. Our verification and evaluation of this mortality data reveals these figures should actually reflect 55 total cases of which 32 patients expired (31 patients died in the hospital and 1 patient died within 30 days following discharge). Various factors contribute to the reasons for our mortality rate being outside the predicted range. The most significant factors for the 31 patients who died in the hospital are as follows: 1) 48% of the patients were over the age of 80 (77% were over the age of 70), 2) 18 or 58% of the 31 patients were coded do not resuscitate (i.e., do not revive) per the patient's and/or the family's request, and 3) the severity of illness of these patients is a key point. From reviewing these patients' medical records it was determined that 71% of these 31 patients had other health conditions (such as cardiogenic shock or refractory congestive heart failure) which contributed to their deaths.

We would like to assure you that we plan to continue to review and to analyze this data. We also intend to utilize the corrected mortality data as a guide in our on-going quality assurance and peer review processes in order to continue to provide our community with the best possible health care.

Medicare Provider #150026
10/22/87

200 High Park Avenue Goshen, Indiana 46526 Phone 219/533-2141

GREENE
COUNTY
GENERAL

LONE TREE ROAD LINTON, INDIANA

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Medicare # 150066

A. Please accept the following comments in regard to the HCFA Mortality Data:

1. The information seems a potentially inaccurate reference as a basis for determining quality of care issues due to:
   a. The sample size in all categories of diagnosis are so small, one or two cases may reflect a wrong rate in our facility.
   b. The population served by our hospital is an older aged market and the age factor used for comparison purposes does not discriminate between a 65 and an 85 year old.
   c. The figures are not adequately adjusted for severity of illness variables.
   d. Coding and hospital record keeping "errors" may cause abnormal results in the reporting of rates per diagnosis and this is not adequately accounted for in the study.
   e. Since all patients discharged within 30 days are included in the statistics, more complex, external and "unpredictable" variables will skew the results for valid comparison purposes.
   f. Where patients came from and how long patients were in the hospital are not adequately given consideration, and yet these factors have definite impact on the statistics provided.
   g. Social and economic factors (i.e. illness prevention and education resources in our community as well as the variety of available and accessible health care providers) are not given enough attention. In our area, unlike some more urban areas, we lack enough family practice physician and social agencies causing patients to develop additional complications and more severe and chronic illnesses.
2. Our hospital representatives fear consumers will draw misleading conclusions from the data.
3. Our hospital, though, will utilize the information in the following methods:
   a. Any diagnosis "out of range" will be used by Medical Staff Committees as a quality assurance indicator to do further studies concerning the management of the cases.
   b. The Utilization Review Committee will analyze the statistics to see if trends develop showing the need to pursue efforts in the:
      1. Prevention of (the severity of) illness before admission
      2. "Continuity of care" considerations after discharge in regard to any "voids" in the health care system.

Thank you for the opportunity to state our point of view.

Sincerely,

Jonas Uland, Executive Director
cc: Ken Stella, IHA
JU/vn

801 N. State Street Greenfield, IN 46140
(317) 462-5544

October 26, 1987

William L. Roper, M.D.
Administration
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Medicare Provider 15-0037

Dear Dr. Roper:

Hancock Memorial Hospital staff have reviewed the HCFA mortality information about Medicare patients treated at this hospital in 1986. We appreciate the opportunity to verify and analyze the data and to submit information from our quality review activities.

The HCFA data regarding dates of admission and number and dates of death have been validated by the hospital Medical Record Department and Administration.

The monitoring of patient care to ensure quality is an ongoing, continuous process at Hancock Memorial Hospital. The Quality Assurance program here includes Medical Staff committee review of the medical records of patient deaths at this facility.

Physician review of the hospital deaths listed in HCFA's data determined death to be the expected outcome or a significant possibility in each case based on end-stage disease process, multisystem complications or condition at the time of admission. Criteria for quality of care were met. Seventy-nine percent (79%) of the medical records document physician and patient and/or family agreement that extraordinary resuscitative measures should not be taken.

Twenty three (23) of the deaths listed in HCFA's data for this hospital occurred after the hospitalization. Deaths in those cases were not unexpected. One of the deaths was a suicide which was unrelated to the diagnosis for hospitalization.

Cause of death was related to a different diagnostic category than that assigned in forty percent (40%) of the hospital deaths. One such case was a hospital admission for treatment of dehydration in a terminal cancer patient who succumbed to the cancer during hospitalization. The death was assigned to the category for dehydration.

Thank you again for the opportunity to comment on the mortality data. If you or anyone receiving this information has additional questions, please do not hesitate to call.

Sincerely,

Fuad M. Hammoudeh
President

Gary C. Sharp, M.D.
Chief of Staff

kl

harrison county hospital
245 ATWOOD STREET • CORYDON, INDIANA 47112 • PHONE (812) 738-4251

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

The in-hospital deaths and patient listings have been verified and found to be correct on the HCFA 1986 mortality rates report for Harrison County Hospital. Observations of the data are as follow:

1. For clarity, suggest having a column for total deaths beside that of the actual mortality rate.

2. The statistical significance of the data in those diagnostic categories with a small number of cases, i.e. SE sepsis only 3 total cases, 1 death, is doubtful.

The categories of CA (Cancer) and PN (Pulmonary) are the only areas where HCH data is at the upper limits of normal predicted mortality rate; all other data reveals HCH rates at either mid-point of the range or lower. It is believed that this reflects both the type of patients we serve and regional practice of hospitalizing patients in the end-stages of terminal illness. The absence of a Hospice or other similar resource/support service impacts also on this practice.

Sincerely,

W E Childers

William E. Childers
Executive Director

INDIANA UNIVERSITY
HOSPITALS

OFFICE OF THE DIRECTOR
University Hospital C118
1100 West Michigan Street
Indianapolis, Indiana 46223
(317) 274-4391

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper,

We welcome the opportunity to comment on the mortality rate information to be released to the public by the Health Care Financing Administration (HCFA). The attempt to inform the public about the quality of care in hospitals is laudable but we have many concerns that the information released will not meet its goal. HCFA has attempted to improve the methodology used since data was previously released in March, 1986. Nevertheless, it is likely an individual hospital's mortality data, for selected Medicare patients, may be accounted for by factors which cannot or have not been incorporated into the current HCFA methodology.

HCFA should emphasize that the data released relate only to the Medicare patient population and cannot be automatically used to make judgements about quality of care of all population groups.

Our specific comments are as follows:

1. The reported mortality rates may be indicators of mortality but the rates do not necessarily reflect the quality of the care provided. The factors utilized in the statistical methodology did not include care assessment.

2. The disease categories do not adequately reflect the severity of illness. Different stages of disease process have varying levels of severity. Two patients may have atherosclerosis, or narrowing of the blood vessels. One patient's disease may be managed with medication while the second patient may require immediate surgical treatment due to the advanced stage and severity of the disease process. The mortality data did not measure the severity of the disease in these cases. In order for this data to be more meaningful, severity of illness must be included in the analysis.

3. The occurrence of death cannot be attributed directly to the care received or not received by the patients. The fact that a death occurred is noted, the cause of death is not noted. Without factoring in the cause of death, the mortality statistics cannot be used to imply a level of quality in the care given by a hospital.

4. The HCFA data is based upon the principal diagnosis for a patient's admission to a hospital. In some cases the cause of death may result from a condition unrelated to that principal diagnosis.

5. Finally, the Health Care Financing Administration data may be interpreted, by the public and others, as indicators of quality of care and as a basis for comparison of hospitals. Since the data is hospital specific, it is not applicable to comparative analysis. The methodology used to develop this data and the potential for its' misinterpretation are significant concerns held by the staff of Indiana University Hospitals.

The Indiana University Hospitals are committed to providing the highest quality care possible. An important part of that process is a willingness to objectively review the care provided. The mortality data provided, based on the limitations noted above, is not an effective way of evaluating quality of care.

Thank you for the opportunity to provide comments on the data.

Sincerely,

George T. Lukemeyer

George T. Lukemeyer, M.D.
Medical Director,
Indiana University Hospitals
Executive Associate Dean,
Indiana University School of Medicine

JOHNSON COUNTY
MEMORIAL HOSPITAL

October 26, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

On behalf of Johnson County Memorial Hospital's Administration and Medical Staff, the following comments are made regarding the HCFA Mortality data.

Upon reviewing the "mortality information" pertaining to Johnson County Memorial Hospital, which HCFA plans to publish, we find it is impossible to duplicate the statistics in order to verify their accuracy. In our opinion, the statistics are virtually meaningless as presented. Regardless of what HCFA claims, unfortunately the public will interpret this meaningless mortality information as a measure of the quality of care provided by a hospital.

Sincerely,

Norbert G. Smith

Norbert G. Smith,
Administrator

NGS/lb

1125 WEST JEFFERSON STREET
FRANKLIN, IN 46131 · 736-3300

LaPORTE HOSPITAL
P.O. Box 250 LaPorte, Indiana 46350-0250 Telephone 219-326-1234

October 21, 1987

William L. Roper, M.D., Administrator
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH and HUMAN SERVICES
Washington, D.C. 20201

RE: HCFA Mortality Data

LaPorte Hospital Medicare
Provider Number - 15-0006

Dear Dr. Roper:

We have completed our initial review of the mortality rate information and appreciate the opportunity to provide our comments. Below you will find our specific comments to the actual data as well as our general comments regarding the uses and limitations of this information.

DATA VERIFICATION

• Without detailed information concerning the billing data available to HCFA in computing the predicted and actual mortality rates, we are unable to verify the accuracy of most of the diagnostic and other data used in your analysis. We did identify one patient on the death list who was not a patient at LaPorte Hospital and two patients listed under incorrect diagnostic categories. The patient identification information is attached for your review and record correction. We are also aware that of the deaths included in your analysis, twenty-three (23)% were alive at the time of dismissal from LaPorte Hospital. Therefore, we cannot verify that these deaths did indeed occur nor the cause of death and if it actually related to their inpatient admission at our hospital.

COMMENTS

• Providing quality care and service to our patients is one of the guiding principles of our mission at LaPorte Hospital. Our Board of Directors, hospital staff, and Medical Staff are committed to providing and ensuring quality services. We have an ongoing and systematic Quality Assurance monitoring process which reviews all cases for a variety of quality indicators including but not limited to: infections, complications, readmissions and deaths. We also review the outcomes of many of the diagnoses treated and procedures performed here. Cases which do not meet the criteria established by the Medical Staff are reviewed in further detail by our physicians. Potential problem areas and opportunities for improvement are identified in this peer review process and the appropriate action is taken. Each of our hospital departments also has a quality assurance program in place which provides for continuous monitoring and identification of opportunities for improvement.

• We view the mortality data calculated by HCFA as a supplement of information to be reviewed within our overall Quality Assurance program. These figures by themselves do not indicate a high or low level of hospital performance but they do

COMMENTS - Continued

provide insight as to areas which might require further review. Similar to the statistical results of our current monitoring process, the figures alone are not significant, but they are useful guides for pointing to areas of potential concern. These areas must be evaluated to determine if there are factors which have not been accounted for which contribute to the overall results. This is particularly true with the mortality rates HCFA has calculated. Factors such as how ill the patient was at the time of admission (the "severity" or stage of the illness) and the patient's socio-economic status influence the outcome of the patient's treatment, but are not taken into account by the model used to calculate these rates. This type of evaluation must take place and be considered with the results of other components of the program before an interpretation of the quality of services provided can occur.

• Even though the data appear to reflect favorably upon LaPorte Hospital in that our mortality rates are within HCFA's "predicted ranges", we think it is critical for the public to understand the appropriate uses and the limitations of this type of information:

Appropriate uses:
- as a guide or screen for the need for further review

Limitations:
- the model reflects only Medicare beneficiaries, not all patients
- reflects the beneficiaries last admission to a hospital in 1986, not each of their stays in 1986
- reflects beneficiaries who died within thirty (30) days of admission, regardless if they were still a patient in the hospital or not, and regardless of the cause of death
- is not a measure for comparing hospitals

Once again, we do appreciate the opportunity to share our comments with HCFA.

Cordially,

Leigh E. Morris
President

Patricia L. Carson
Director Patient Care Review
and Reimbursement

10/21/87
LEM:PLC:tp

ATTACHMENT I

LaPORTE HOSPITAL, INC.

COMMENTS ON HCFA MORTALITY DATA

° The folowing patient is listed as a LaPorte Hospital patient but in fact was never seen at LaPorte Hospital*.

Last Name (First 6 letters)	HIC #	Admission Date	Discharge Date	Diagnostic Category
[redacted]	[redacted]	5-24-86	5-24-86	UN

92 years old male

* This was a billing error by another Indiana Hospital and was corrected in August, 1987.

° The following two patients have an inaccurate principal diagnosis code and therefore are listed in an incorrect diagnostic category on the HCFA list:

Last Name	HIC #	Admission Date	Discharge Date	Correct Principal Diagnosis Code
[redacted]	[redacted]	4-11-86	4-18-86	162.3
[redacted]	[redacted]	2-16-86	2-16-86	436

	Correct Diagnostic Category	Incorrect Diagnostic Category
[redacted]	CA	ME
[redacted]	CE	PN

Home
Hospital

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
Room 314 G
Hubert Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Dear Doctor Roper:

RE: HCFA MORTALITY DATA RESPONSE

Though the mortality statistics for Home Hospital as published by HCFA are within the predicted range of mortality rates in all seventeen categories surveyed, we feel that such an analysis should not be considered as an accurate measure of the quality of care practiced at this or any institution. Statistics compiled for this study have not taken into account many of the very real elements that influence patient outcome and survival rates such as case mix, lifestyle before and after illness, acuity or severity of illness, nor any of the critical socio-economic and demographic factors that can often effect mortality statistics. We are in agreement with HCFA Administrator William L. Roper's analysis of the mortality statistics, "...the information on its own is not a complete measure of the quality of care at an individual hospital." He continues by saying, "...until we have developed additional statistical measures to deal with complex issues such as severity of the illness, we can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital..."

Such raw data does not differentiate the long term terminal patient from those patients that died unexpectedly, and is flawed in that patients are categorized by the principal diagnosis of that admission (i.e., hip fracture/orthopedic condition) instead of the actual cause of death (i.e., myocardial infarction).

2400 South Street, Lafayette, Indiana 47904-3027
Telephone (317) 447-6811

A study such as this highlights death and the hospital industry, and ignores the driving purpose of hospitals, which is to maintain and/or restore health.

Sincerely,

Franklin E. Simek, President
Medicare Provider Number: 150109

FES/rjc

MEMORIAL HOSPITAL
OFFICE OF THE PRESIDENT • 615 N. MICHIGAN ST. • SOUTH BEND, IN 46601-9986 • (219) 284-7251

October 26, 1987

Dr. William L. Roper
Administrator
Health Care Finance Administration
Health Standards and Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We are writing to you in response to the Health Care Financing Administration Medicare mortality information which was sent to Memorial Hospital of South Bend earlier this month. Thank you for the opportunity to review and comment on the data.

Although we have done our best to clarify any discrepancies in the data, we want to state clearly that we concur with you that the information on its own is not a complete measure of the quality of care at Memorial Hospital. Attached are several comments specifically detailing factors the public should consider in interpreting this information for Memorial Hospital of South Bend. In addition, we have outlined discrepancies in the data which were identified by our Medical Records and Quality Assurance Departments when comparing the data to our own statistical reports and medical records.

We appreciate your sensitivity in allowing us to analyze the Medicare mortality information and hope that the comments we are returning to you provide additional insight into the interpretation of the data for Memorial Hospital of South Bend.

Sincerely,

Harold E. Slutsky

Mr. Harold Slutsky, Chairman
Board of Trustees Committee
on Quality Assessment

James Grainger, M.D.
Chairman, Medical Staff
Quality Assessment Committee

attachments

MEMORIAL HOSPITAL OF SOUTH BEND

Comments Regarding the Health Care Financing Administration Mortality Rates

Memorial Hospital of South Bend has actual mortality rates for all 16 diagnostic catagories that fall within the range of predicted mortality rates set by the Health Care Financing Administration. Although we have done our best to clarify any discrepancies in the data, we want to concur that the information on its own is not a complete measure of the quality of care at Memorial Hospital. Following are several comments specifically detailing factors the public should consider in interpreting this information for Memorial Hospital of South Bend:

1. The Health Care Financing Administration (HCFA) has reported to hospital's across the nation that, "the information on its' own is not a complete measure of the quality of care at any individual hospital." In addition, HCFA claims that until they have "developed additional statistical measures to deal with complex issues such as severity of illness, they cannot and do not recommend the use of the information by itself to make judgements about quality of care in an individual hospital or to make comparisons among hospitals."

   In addition, the model used by HCFA to predict hospital mortality rates fails to consider the wide range of factors with significant impact on mortality. Examples include, but are not limited to, the patient's general health status, the stage or acuity of the patient's illness, patient's psychological condition and family support.

2. Memorial Hospital of South Bend feels it is more appropriate to monitor all inpatient deaths on an individual basis and in doing so, takes into consideration a thorough review of the information contained within a patient's medical record. This allows Memorial Hospital to consider all information in assessing the timeliness and appropriateness of care provided.

3. In general, the deaths at Memorial Hospital of South Bend reported by HCFA were the "expected outcome" at the time the patient was admitted or discharged. For example, the HCFA data base includes a group of patients with terminal cancer who requested extraordinary efforts not be given, but to let nature take its course so they might die with dignity. Therefore, the hospital mortality rate reflects the Hospital's efforts to accommodate the patient's individual rights.

4. The use of 30 day post admission mortality rates results in the attribution to the Hospital of deaths that are unrelated to the condition of the patient. Also, HCFA does not take into account the cause of death. Patients are arbitrarily placed in categories that relate to their last hospital stay, not necessarily reflecting their true cause of death.

5. The medical mortality rates reported for certain diagnostic categories are influenced by the fact that Memorial Hospital of South Bend is a regional referral center for cancer, heart, trauma and rehabilitation services. Therefore, Memorial Hospital offers services that attract patients with a higher than average expected mortality. The majority of diagnostic categories reported by HCFA fall into these specialty areas.

6. The HCFA data is not an accurate representation of the mortality rates the general population may expect at Memorial Hospital of South Bend. HCFA calculates mortality rates based upon Medicare patients only. The average age of the Medicare patients at Memorial was 77 years old. Persons who qualify for Medicare tend to incur more frequent medical problems and require more health care services than other segments of the population. Because of this, their mortality rate is significantly higher than other population segments.

7. HCFA only considers the last Medicare admission to a hospital prior to death. Therefore, prior admissions to a hospital which resulted in something other than death as an outcome are not reflected in the mortality rate.

ERRORS IN HCFA'S REPORTED MORTALITY RATE

A. Patients who were never treated at Memorial Hospital during 1986:

1. PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME:
DIAGNOSTIC CATEGORY: UN
DATE OF ADMISSION: 01-29-86
DATE OF DEATH: 02-02-86
AGE: 91 SEX: Female
PRINCIPAL DIAGNOSIS: 785.4
DATE OF DISCHARGE: 02-02-86

The following information is identical to the patient listed directly above:

PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME:
DIAGNOSTIC CATEGORY: UN
DATE OF ADMISSION: 01-29-86
DATE OF DEATH: 02-02-86
AGE: 91 SEX: Female
PRINCIPAL DIAGNOSIS: 785.4
DATE OF DISCHARGE: 02-02-86

B. Patients who were treated at Memorial Hospital, but whose dates of admission, discharge or death are incorrect:

1. PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME:
DIAGNOSTIC CATEGORY: CA
DATE OF ADMISSION: 03-17-86
DATE OF DISCHARGE: 03-27-86
AGE: 73 SEX: Male
PRINCIPAL DIAGNOSIS: 819.0

MEDICARE'S DATE OF DEATH: 03-28-86

MEMORIAL'S DATE OF DEATH: 03-27-86

2. PATIENT ID NUMBER (HIC): [redacted]
PATIENT"S SURNAME:
DIAGNOSTIC CATEGORY: CE
DATE OF ADMISSION: 12-08-86
DATE OF DISCHARGE: 12-09-86
AGE: 52 SEX: Male
PRINCIPAL DIAGNOSIS: 189.0

MEDICARE'S DATE OF DEATH: 12-10-86

MEMORIAL'S DATE OF DEATH: 12-09-86

*3. Medicare's data does not show the last admission where patient died in- house:

PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: HL
AGE: 62 SEX: Male
PRINCIPAL DIAGNOSIS: 427.89

MEDICARE'S DATA:
ADMITTED: 10-10-86
DISCHARGED: 10-15-86
DATE OF DEATH: 10-21-86

MEMORIAL'S DATA:
ADMITTED: 10-20-86
DISCHARGED: 10-21-86
DATE OF DEATH: 10-21-86

4. PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: HS
DATE OF ADMISSION: 11-26-86
DATE OF DISCHARGE: 11-26-86
AGE: 84 SEX: Female
PRINCIPAL DIAGNOSIS: 427.5

MEDICARE'S DATE OF DEATH: 11-28-86

MEMORIAL'S DATE OF DEATH: 11-26-86

*5. Medicare's data does not show the patient's last hospital stay where patient died in-house:

PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: ME
AGE: 76 SEX: Male
PRINCIPAL DIAGNOSIS: 276.5

MEDICARE'S DATA:
ADMITTED: 07-06-86
DISCHARGED: 07-10-86
DATE OF DEATH: 07-25-86

MEMORIAL'S DATA:
ADMITTED: 07-18-86
DISCHARGED: 07-25-86
DATE OF DEATH: 07-25-86

6. PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: PN
DATE OF ADMISSION 04-02-86
DATE OF DISCHARGE: 04-13-86
AGE: 79 SEX: Female
PRINCIPAL DIAGNOSIS: 486.0

MEDICARE;S DATE OF DEATH: 04-14-86

MEMORIAL'S DATE OF DEATH: 04-13-86

*7. Medicare's data does not show patient's last hospitalization where patient died in-house:

PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: UN
AGE: 68 SEX: Female
PRINCIPAL DIAGNOSIS: V581.0

MEDICARE'S DATA:
ADMITTED: 09-18-86
DISCHARGED: 09-19-86
DATE OF DEATH: 10-02-86

MEMORIAL'S DATA:
ADMITTED: 10-06-86
DISCHARGED: 10-07-86
DATE OF DEATH: 10-07-86

*8. Medicare's data does not show patient's last hospitalization where patient died in-house:

PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: CA
AGE: 56 SEX: Male
PRINCIPAL DIAGNOSIS: 150.8

MEDICARE'S DATA:
ADMITTED: 12-15-86
DISCHARGED: 12-29-86
DATE OF DEATH: 01-09-87

MEMORIAL'S DATE:
ADMITTED: 12-30-86
DISCHARGED: 01-10-87
DATE OF DEATH: 01-10-87

*9. Medicare's data does not show patient's last hospitalization where patient died in-house:

PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: HM
AGE: 71 SEX: Female
PRINCIPAL DIAGNOSIS: 599.0

MEDICARE'S DATA:
ADMITTED: 12-19-86
DISCHARGED: 12-23-86
DATE OF DEATH: 01-04-87

MEMORIAL'S DATA:
ADMITTED: 12-03-86
DISCHARGED: 01-04-87
DATE OF DEATH: 01-04-87

*10. Medicare's data does not show patient's last hospitalization where patient died in-house:

PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: HS
AGE: 56 SEX: Female
PRINCIPAL DIAGNOSIS: 410.9

MEDICARE'S DATA:
ADMITTED: 12-15-86
DISCHARGED: 12-23-86
DATE OF DEATH: 01-04-87

MEMORIAL'S DATA:
ADMITTED: 12-27-86
DISCHARGED: 01-04-87
DATE OF DEATH: 01-04-87

*11. Medicare's data does not show patient's last hospitalization where patient died in-hosue:

PATIENT ID NUMBER (HIC): [redacted]
PATIENT'S SURNAME: [redacted]
DIAGNOSTIC CATEGORY: PN
AGE: 75 SEX: Male
PRINCIPAL DIAGNOSIS: 486.0

11. Con't

MEDICARE'S DATA:

ADMITTED:	12-18-86
DISCHARGED:	12-24-86
DATE OF DEATH:	01-09-87

MEMORIAL'S DATA:

ADMITTED:	12-28-86
DISCHARGED:	01-09-87
DATE OF DEATH:	01-09-87

C. Patients who were still alive when discharged; or

D. Patients who were still alive more than 30 days after discharge, as indicated by a subsequent entry in the patient's medical record of physician report:

PATIENT ID NUMBER (HIC):	[redacted]
PATIENT'S SURNAME:	
DIAGNOSTIC CATEGORY:	HM
AGE: 76 SEX:	Male
PRINCIPAL DIAGNOSIS:	425.4

MEDICARE'S DATA:

ADMITTED:	07-05-86
DISCHARGED:	07-07-86
DATE OF DEATH:	07-07-86
PRINCIPAL DIAGNOSIS:	425.4

MEMORIAL'S DATA PER MEDICARE'S LISTED ADMISSION:

ADMITTED:	07-04-86
DISCHARGED:	07-07-86
PRINCIPAL DIAGNOSIS:	250.0

PATIENT'S LAST HOSPITAL ADMISSION:

ADMITTED:	03-25-87
DISCHARGED ALIVE:	04-02-87

*Medicare's data does not show the patient's last hospitalization where the patient expired while in-house.

Logansport Memorial Hospital

COMMENTS ON THE HCFA MORTALITY DATA

MEMORIAL HOSPITAL
LOGANSPORT, INDIANA

The data used by HCFA indicate that the total of 117 Medicare patients admitted to Memorial Hospital died within thirty days of discharge. Of these, 91 died while still a patient in the hospital while 26 died after discharge. Our own records indicate that 1303 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Memorial Hospital is correct. It is impossible to determine the percentage of the 26 patients dying after discharge, who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

In all diagnostic categories, Memorial's actual mortality rate falls within the range of the predicted mortality rate; however, that does not relieve the concerns over the method used to determine predicted mortality rates. HCFA itself believes that while information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, one cannot recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals.

The statistical model developed by HCFA measures the relationship between a limited number of patient characteristics and the risk of death. The model does provide accurate and reliable estimates of the relationship between each of the five patient characteristics included in the model and the risk of death. Whether these are the most significant factors influencing the risk of death is unknown, but the limited ability of these factors to explain differences in mortality rates between hospitals suggests they are not.

First the reliability of the model is unknown, but appears to be quite limited. That is, the model may accurately and reliably reflect the relationship between the small number of patient characteristics and the risk of death, but it does not reliably predict hospital mortality rates. The model fails to consider a wide range of factors with a significant impact on mortality. Examples include but are not limited to the patient's general health status, stage of the patient's illness, the patient's psychological condition and family support. Moreover, changes in the way in which certain patient characteristics are measured result in changes in the predicted mortality rates for individual hospitals. The "right way" of measuring these factors is still a source of dispute.

1101 Michigan Avenue • Logansport, Indiana 46947 • (219) 753-7541

The second and more serious limitation of the model is that it has not been validated. As noted above, deviations from the predicted mortality rate could indicate some problem with the quality of care in that hospital, but it could also reflect exclusion from the model of significant factors influencing the risk of death. Whether the hospitals whose actual mortality rates are outside a predicted range are more or less likely to provide higher or lower quality care is unknown. Statistical analysis of mortality rates can do no more than screen for further review. The study conducted by HCFA raises important questions but they cannot answer them. Quality judgments can only be made after reviewing the information contained in the patient's medical record.

In addition, the use of a thirty day post admission mortality rate will reduce apparent variations in mortality due to differences in length of stay. However, it will also result in the attribution to the hospital of deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge or that resulted from the management of the patient at home or in a post-acute care facility.

It is important to realize that Memorial Hospital, which is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations and licensed by the State Board of Health, maintains a comprehensive quality assurance program. Staffed by two full time employees, the Q.A. Program oversees chart review, problem identification and resolution, and other activities of all the services within Memorial. Medical staff clinical activities are thoroughly reviewed through the use of peer review and credentialling activities.

The Q.A. Committee and committees in every clinical section spend over a hundred hours each month reviewing quality issues. All mortality as well as other adverse outcomes, patient incidents, and various clinical issues are reviewed by the medical staff in these committees. The purpose of this extensive review is to identify problems or adverse trends in the delivery of care and follow through on corrective actions to ensure that quality care is provided to every patient.

MEMORIAL HOSPITAL
and Health Care Center

800 W. 9th Street • Jasper, Indiana 47546 • (812) 482-2345

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

October 15, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P O Box 26684
Baltimore, MD 21207

Re: Selected Mortality Information
Hospital I.D. #: 150115

Dear Dr. Roper:

Memorial Hospital and Health Care Center falls out of the range of the predicted mortality rates in one diagnostic category: SE - Sepsis. This involves a single patient in this category. While this death was not expected at the time of admission, it was a very significant possibility due to the patient being under treatment for a severe, chronic condition.

The validity of these statistics must be questioned, however, because there was only one patient in the category with the death resulting in a 100% mortality rate, while the guidelines range from 2-99%. A single patient in a category cannot yield accurate results. With this in mind the hospital concludes that the statistical model is basically flawed. Additionally, the absence of severity of illness data is another major flaw in the mortality data as it appears. Without a reliable method of measuring severity, valid conclusions on the data cannot be drawn.

Very truly yours,

MEMORIAL HOSPITAL AND
HEALTH CARE CENTER

Herman A. Kohlman

Herman A. Kohlman
President

sjl
088

MEMORIAL HOSPITAL OF MICHIGAN CITY
Fifth and Pine Streets Michigan City, Indiana 46360 (219) 879-0202
(219) 326-7427

October 27, 1987

William M. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to provide input and respond to the release of data on hospital mortality rates for 1986.

Memorial Hospital of Michigan City is a 102 bed acute care facility whose case mix includes patients with major medical and surgical illnesses. We offer comprehensive services in Cardiology, Obstetrics and Gynecology, Chemotherapy, Emergency and Intensive Care, as well as providing a full array of general, acute care services.

The medical and nursing staff at Memorial Hospital of Michigan City conduct an in-depth review of the medical record of every patient treated at this facility regarding medical management and overall care. Additionally, incorporated in this review are the records of every patient who expires at the hospital.

Hospitals are monitored by several outside agencies to assure that certain standards of patient care are maintained. Included are the Joint Commission on Accreditation of Health Care Organizations, the Indiana State Board of Health, and peer review organizations. Memorial Hospital of Michigan City continues to be fully accredited by the Joint Commission as it has been since the Commission's inception. We are licensed and annually inspected by the Indiana State Board of Health to insure full compliance with all standards. Likewise the Federal Government through the organization Peer Review, monitors the care provided for every Medicare patient treated in our hospital.

Our hospital's specific mortality data reported by HCFA has been fully reviewed by the President of the Medical Staff, the Physician Chairman of the Utilization Review Committee, Directors of Utilization Review, Quality Assurance, and

Medical Records. Statistics indicate that we fall within the predicted range of mortality rates in all areas reported. Any area that exceeds predicted ranges is called an "outlier". Memorial Hospital of Michigan City has no areas in the "outlier" category. Based on the data released by HCFA, we specifically reviewed the medical records of the Medicare patients in which the largest number of Medicare deaths occurred.

Cancer: In 1986, we treated 16 cancer patients, 9 of whom died. Review of the deaths due to cancer indicates that there was a significant spread of their cancer at the time of admission. They also suffered from other serious medical diseases of the heart, lungs and kidneys which limited the ability to treat the cancer with chemotherapy and/or radiation.

Stroke: Of the 9 stroke patients we treated, 5 died. The majority of the patients who expired because of stroke were admitted in coma or with significant paralysis, with the median age being 83. Their advanced age along with significant underlying medical problems with heart, lungs and/or kidneys lead to their death.

Again, thank you for the opportunity to present this information.

Sincerely,

Norman D. Steider,
Hospital President

Burton B. Ruby
Chairman of the Board

Charles T. Janovsky, M.D.
Chief of Staff

NDS:jk

Methodist Hospital OF INDIANA, INC.

1701 North Senate Boulevard
Indianapolis, IN 46202
(317) 929-3800

FRANK P. LLOYD, M.D.
President

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Methodist Hospital of Indiana continues to support the efforts of the Health Care Financing Administration to develop data for the prediction and measurement of mortality rates. You have pointed out the obvious deficiencies and limitations of the present attempt.

The continuation of this attempt will no doubt help in the development of education programs that will result in improvements in the quality of care for patients.

At the same time, Methodist will not allow the publication of such data to reduce our efforts to continue to explore new and different methods of care for those who are most critically ill. We believe these efforts will also result in improvements in the quality of care and outcomes for patients.

Sincerely,

Frank P. Lloyd, M.D.

jlt

THE METHODIST HOSPITALS

Northlake Campus
Corporate Office
600 Grant St.
Gary, IN 46402
(219) 886-4000

Southlake Campus
8701 Broadway
Merrillville, IN 46410
(219) 738-5500

Provider #15-0002 Provider #15-0132

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Avenue South West
Room 314G
Washington, D.C. 20201

Dear Dr. Roper:

In response to your September 21, 1987 communication regarding the intended release of mortality rate data for 1986, please note the following:

The Methodist Hospitals serve as a regional referral center for communities throughout Northwest Indiana. Diagnostic and treatment capabilities which attract physicians and their patients to the hospital include:

Cancer Center
.Oncology Units
.Radiation Therapy
.Diagnostic Capabilities
.Mammography
.Hemotherapy

Gerontology
Support and education for caregivers through clinical specialist nurses

Cardiac Services
.Cardiac Rehabilitation
.Cardiac Catheterization
.Open Heart Surgery
.Coronary Angioplasty

Imaging Services
.Full Service Diagnostic
.Radiology Services (CT Scan, X-Ray)
.Magnetic Resonance Imaging Services
.Active Interventional Radiology

Emergency Medical Services
.Trauma Alert Program
.Regional Coordination Center for emergency medical serivces for 7-county area
.Intensive Care/Coronary Care Units

Renal Services
.Inpatient/Outpatient Services
.Dialysis

Neuro Behavioral Medicine
.Adult Psychiatry
.Child and Adolescent Psychiatry
.Alcoholism and other Chemical Dependencies

Rehabilitation Services
Since 1971, we have been accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), with a full complement of Physical Therapy, Occupational Therapy, Speech and other Rehabilitative Services.

NeuroScience Units
Neurosurgical services

Specialty Health Centers
.Eye
.Pulmonary
.Lupus
.Arthritis

All patients listed for the Northlake and Southlake Campuses with the exception of one, were patients who had been hospitalized at the Methodist Hospitals during the year 1986.

The hospital has a well-established quality assurance process which includes mortality review. All deaths are reviewed from a nursing and physician standpoint to evaluate the quality of patient care management.

It is significant to note that the leading causes of death are consistent with those of the nation and the state. The leading causes of death for the State of Indiana in 1985 were diseases of the heart (1), cancer (2), cerebrovascular disease (3), and chronic obstructive pulmonary disease (4). In reviewing the data of The Methodist Hospitals, the leading causes of death are the same - consistent with both state and national data.

The HCFA model considers several patient variables in its calculation of the data presented, including age, sex, principal diagnosis, additional diagnoses and numbers of prior hospitalizations. Upon review of The Methodist Hospitals data, it was found that a significant number of patients, approximately 50%, had one or more significant co-existing conditions in addition to that condition which necessitated hospitalization. This is consistent with the hospital's role as a regional referral center for cardiovascular disease, cancer, renal disease, pulmonary disease, etc.

Further attesting to the severity of illness of patients treated at The Methodist Hospitals is the primary admission source, the emergency room. More than 60% of the Medicare patients included in the mortality data presented at the emergency room and were determined to require inpatient treatment. Also, we receive many elderly patients from area nursing homes when healthcare requirements necessitate an acute care setting.

It is the philosophy of the hospital to meet the healthcare needs of the community, ranging from those who are ambulatory to the critically ill. The increasingly aging population of the Northwest Indiana communities allows us to serve a significant percentage of Medicare patients - 23.9% of all Lake County residents ages 65 or older.

Because the data presented for each hospital is hospital - specific (considering the specific patient population of the hospital and hospital services provided), it will be of little value to consumers to compare hospitals on the basis of the data presented. Many factors of course, enter into an assessment of hospital performance, of which mortality is but one.

Until the parameters to be used by consumers, hospitals and Peer Review Organizations for the determination of the presence or absence of quality care are defined, the assessment of quality from models currently in use is limited to inference rather than measurement. Thus, Medicare recipients are encouraged to discuss the mortality data with their physicians for a better understanding of factors influencing quality of care rendered in a hospital setting.

Thank you for the opportunity to comment.

Sincerely yours,

John H. Betjemann
President

Hakam Safadi, M.D.
President
Medical Staff

JHB/HS/dg
0050G/1-3

Our Lady of Mercy Hospital
U.S. Highway 30 Dyer, Indiana 46311-1799 (219) 865-2141

October 23, 1987

Mr. William L. Roper, M.D.
Administrator
Department of Health and Human Services
Washington, D.C. 20201

RE: Our Lady of Mercy Hospital
Medicare Provider #150090

Dear Mr. Roper:

We are in receipt of your letter of September 21, 1987, and we thank you for allowing us the opportunity to respond to our hospital's mortality statistics.

We are pleased to note that our actual mortality rates are all either within range of predicted mortality or lower. Upon closer analysis of the data, we have found no areas of concern about the quality of patient care.

We would, however, like to state our general concern about the statistical percentages that are based upon very small subsections of the population. We feel that these percentages can be misleading when based upon numbers of cases that are not statistically significant. We would like to request HCFA's cooperation in eliminating low volume subsets from the published reports.

Sincerely yours,

J. Donald Manchak
President and Chief
Executive Officer

JDM:bb

PARKVIEW

PARKVIEW MEMORIAL HOSPITAL
2200 Randallia Drive Fort Wayne, Indiana 46805 Telephone (219) 484-6636

October 26, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Subject: Medicare Mortality Comments
Medicare Provider No: 150021

Dear Dr. Roper:

Parkview Memorial Hospital has reviewed the HCFA mortality information about Medicare patients treated in 1986. The following paragraphs reflect Parkview's response for publication. In addition, corrections to the HCFA data are enclosed as requested.

Comments for Publication

Of the 16 diagnostic categories reported in the HCFA data, Parkview's mortality rates fall consistently within the range of predicted mortality. In fact, Parkview Memorial Hospital has been consistently below state and national averages for Medicare mortality rates.

The HCFA mortality methodology accounts for only those Medicare beneficiaries whose last admission to the hospital involved 30 days or less length of stay. Additionally, the HCFA data does not take into account patients initially treated at surrounding healthcare facilities, and then transferred to Parkview. Parkview Memorial Hospital is a regional referral center accepting acutely ill patients. Thirty-seven percent (37%) of the cases in the HCFA analysis were transfer patients from outlying healthcare facilities.

The data used by HCFA indicates that a total of 460 Medicare patients admitted to Parkview Hospital died within 30 days of last admission. Of these, the HCFA data identified 361 died while still a hospital patient, and 99 died after discharge. Actual review of the Parkview medical records was performed to verify these statistics. It is impossible to determine the accuracy of the HCFA information regarding those patients who presumably died after discharge. Information concerning death after discharge is not included in the medical record, nor may the actual death be related to the cause for admission.

The reliability and validity of the HCFA model is unknown and excludes significant factors that impact on mortality. These include the patient's general health status, the degree or stage of the patient's illness, the psychological condition and family support.

Statistical mortality rates cannot measure the quality of care and facility provides. At best, statistical information can only be used to identify significant variances which point to the need for further in-depth review.

Review of all deaths is consistently performed at Parkview Memorial Hospital by a peer review process, as recommended by the Joint Commission on Accreditation of Healthcare Organizations.

Sincerely,

Mark Slen

Mark Slen,
President

ah

Enclosure

HCFA MORTALITY RATES

CORRECTED DATA

Patient ID Number (HIC)	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Principal Dx	Principal Procedure
[redacted]	[redacted]	CA	75	F	02/04/86	02/07/86	*Alive 02/07/86	1976	
[redacted]	[redacted]	CA	71	M	01/31/86	02/03/86	*Alive 02/03/86	1985	
[redacted]	[redacted]	CA	71	M	10/05/86	10/06/86	* 10/06/86	1977	
[redacted]	[redacted]	CA	69*	M	01/09/86	01/09/86	01/09/86	1629	
[redacted]	[redacted]	CE	80	F	11/03/86	11/05/86	* 11/05/86	4349	8703
[redacted]	[redacted]	CE	68*	M	05/08/86	05/19/86	05/19/86	436	8872
[redacted]	[redacted]	CE	88	F	12/11/86	* 12/12/86	* 12/12/86	436	
[redacted]	[redacted]	CE	88*	M	05/12/86	06/04/86	06/04/84	436	
[redacted]	[redacted]	CE	66	F	12/18/86	12/19/86	* 12/19/86	431	8703
[redacted]	[redacted]	CE	85	F	12/13/86	12/26/86	* 12/26/86	436	8703
[redacted]	[redacted]	GC	82	M	12/11/86	12/13/86	* 12/13/86	5570	9604
[redacted]	[redacted]	GI	63*	F	01/18/86	01/22/86	02/07/86	5301	

IN 77.2

Patient ID Number (HIC)	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Principal Dx	Principal Procedure
[redacted]	[redacted]	GU	72	M	02/11/86	02/13/86	02/13/86	5990	
[redacted]	[redacted]	GU	89*	F	09/13/86	09/20/86	09/20/86	5990	
[redacted]	[redacted]	HL	73	M	04/12/86	04/12/86	04/12/86	4111	3722
[redacted]	[redacted]	HL	86	F	08/24/86	08/27/86	08/27/86	42781	
[redacted]	[redacted]	HL	85	M	10/09/86	10/18/86	10/18/86	4293	8872
[redacted]	[redacted]	HM	87	M	12/04/86	12/26/86	12/26/86	5184	9604
[redacted]	[redacted]	HS	67	F	02/09/86	02/17/86	02/17/86	4275	8914
[redacted]	[redacted]	HS	78	F	01/30/86	01/31/86	01/31/86	4275	3891
[redacted]	[redacted]	HS	77*	M	05/09/86	05/09/86	05/09/86	4413	3844
[redacted]	[redacted]	PN	99*	F	01/23/86	02/17/86	02/17/86	486	3491
[redacted]	[redacted]	RN	63	M	04/09/86	04/12/86	04/12/86	585	8875
[redacted]	[redacted]	UN	48	M	06/19/86	07/04/86	07/04/86	80702	
[redacted]	[redacted]	ME	51	F	01/07/87	01/09/87	01/09/87	162.9	

*Area of Correction

IN 773

Perry County
Memorial Hospital
#1 Hospital Road
Tell City, IN. 47586
Telephone (812) 547-7011

Bradford W. Dykes
Administrator/Chief Executive Officer

Medicare Provider #
15-0070

October 12, 1987

William L. Roper, M.D.
Administrator
Department of Health &
Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

The mortality rates and information you sent specific for this facility has been reviewed by the medical staff, administration, and several medical staff committees, including Utilization Review, Quality Assurance and Medical Care Evaluation. It is noted that statistics for our facility were within the range of predicted mortality rates for all diagnostic categories listed.

Peer review done within our facility reflect that our patients receive quality care. HCFA's statistics would appear to reinforce this. However, we feel that HCFA's mortality statistics are very limited in the information they offer, and do not reflect the true quality of patient care in any facility. It is our hope that when this information is published in December, HCFA will make clear to the public that the information should not be used to judge the quality of care in any individual hospital as stated in the first paragraph on page 3 of your letter. Giving the public information without a clear and simple explanation is always more detrimental than helpful. Since this information must be published, hospitals and physicians must entrust HCFA with the responsibility of providing the appropriate explanations with the statistics.

Sincerely,

Rebecca Elder, R.N.
Resource Utilization Director

RE/jz

Promoting tomorrow's health through today's caring.

Arthur S. Malasto
Administrator

PORTER MEMORIAL HOSPITAL

814 LaPorte Avenue • Valparaiso, Indiana 46383
Telephone (219) 465-4600

TRUSTEES
James J. Crandall
President
Roger K. Claudon
Vice President
Suzanne Perkins
Secretary
Warren H. Canright
Eugene E. Kopczak
Chen T. Sun, M.D.
Leonard A. Troman

October 22, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Department of Health and
Human Services
Washington, DC 20201

Dear Dr. Roper:

We have received the Healthcare Financing Administration (HCFA) Mortality Data for Porter Memorial Hospital **(Medicare Provider #150035)** and would like to offer the following comments:

1. We have reviewed the 10 high risk and 6 low risk diagnostic categories and have observed Porter Memorial Hospital to have an actual mortality rate for 1986 which falls within the predicted mortality rates developed by HCFA.

2. The total number of Medicare patients included in the HCFA sample represents approximately 70% of the Medicare patients admitted to Porter Memorial Hospital during 1986. In 1986, there were a total of 3,508 Medicare patients admitted to Porter Memorial Hospital, 298, or 8.5% of whom expired at Porter Memorial Hospital.

3. Fifty four (54), or 17% of the 309 Medicare deaths included in the HCFA data occurred after the patient had been discharged from Porter Memorial Hospital.

4. The Medical Staff of Porter Memorial Hospital conducts a thorough Quality Assurance Program which evaluates the quality of care provided to patients of Porter Memorial Hospital, with particular attention given to patients who died at the hospital.

VHA.
Affiliate of Voluntary Hospitals of America, Inc.

In summary, given the fact Porter Memorial Hospital is a referral center for the area, providing extensive programs in Oncology Care, Cardiology, Pulmonary Disease, and Trauma, we feel our mortality statistics are appropriate for the type of patients we serve.

Even though we are pleased with these statistics, we do not believe the HCFA Mortality Data is, in itself, a complete and accurate measure of the quality of care provided by any institution; rather, quality of care is evaluated through our Quality Assurance Program.

Sincerely,

Arthur S. Malasto

Arthur S. Malasto
Administrator

ASM/jsh

cc: President, Board of Trustees
President, Medical Staff

Putnam County
Hospital

October 27, 1987

HEALTHCARE FINANCING ADMINISTRATION
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

ATTN: Dr. Roper

Following a complete analysis of the mortality information attributed to Putnam County Hospital in Greencastle, Indiana, we have determined that 4 cases out of the 103 listed need data corrections as follows:

HIC #/PATIENT NAME	PROBLEM
[redacted]	incorrect date of death -- 4/30/86; date of death should be 4/6/86
[redacted]	incorrect date of death -- 2/22/86; date of death should be 2/24/86
[redacted]	incorrect date of death -- 5/25/86; date of death should be 5/23/86
[redacted]	incorrect dates for last hospital stay -- 5/13-14/86; should be 5/15 thru 6/12/86 with date of death as 6/12/86

All other cases reviewed contained correct data in terms of the former patients actually having died and on the date indicated by HCFA. Previous stay dates were also correct.

Please make these corrections to the data file for Hospital number 150027 -- Putnam County Hospital in Greencastle, Indiana.

Yours very truly,

Donna Gannaway

Donna Gannaway, RRA
Dir. of Information Services

reid memorial hospital

October 16, 1987

Health Care Financing Administration Health Standards
and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Improving the quality of medical care is a primary goal of Reid Memorial Hospital. Measuring, analyzing and distributing information about quality is crucial to achieving that goal. Pertinent data on a hospital's performance can assist the hospital in self-assessment and the public with their health care decisions. To that extent, we commend the Health Care Financing Administration (HCFA) for working toward a common goal.

The attached disclosure of hospital mortality rates is a poor attempt, though, of demonstrating the quality of care provided by hospitals. HCFA has compiled data on Medicare patients who have died within 30 days of being discharged from the hospital. In addition to publicizing actual mortality rates, HCFA has predicted what mortality rates should be for hospitals. The mortality figures account for Medicare patients admitted during 1986. Those who died between January 1, 1986 and January 31, 1987 are counted in the statistics. At Reid, Medicare patients comprise less than half our patient census. The HCFA data only addresses a minority of the patient population. At best, the statistics are misleading, at worst, they are damaging and do a disservice to hospitals and the public.

For a hospital Reid's size, HCFA predicts a mortality rate between 9 and 15 percent. Based on their findings, Reid's mortality rate is 11 percent. Although we fall in the lower portion of the predicted range, we are still concerned about the flawed methodology used to obtain these figures and their value.

It is our belief that mortality rates alone are clearly not quality indicators. Choosing a hospital based solely on the raw numbers is to make a decision based on partial knowledge. The published mortality rates in themselves are inconsistent. The only facts one can obtain from the data is the number of Medicare patients at Reid who died. The figures are calculated based on the patient's age, sex, principal diagnosis and date of admission. In their efforts, HCFA has neglected to examine the severity and intensity of illness, genetic factors, pre-existing medical and psychological

1401 chester boulevard • richmond, indiana 47374 • phone 317 / 983-3000

conditions, diet, adherence to post discharge instructions, home and other environmental factors and patient transfers. Although HCFA recognizes these are important factors which will be studied in the future, the 1986 data is skewed and invalid without them.

Another area which has been discounted is the services available at a particular hospital. Reid operates a cancer and blood disease center, a long-term care facility, hospice and intensive/coronary care unit. These services attract patients with a higher than average expected mortality rate. Often times, the expected outcome is death. Of the deaths which occurred within 30 days of discharge, 85 percent died in nursing homes, hospice or at other facilities. This should be reflected in the data and hospitals should not be discriminated against for offering a high level service to their communities.

At Reid, we do not have the answers for HCFA, only some for our community and the people we serve. As part of our mission, we believe it's a top priority to provide the highest quality of care possible. To monitor and evaluate ourselves, we have a quality assurance program. It is a systematic regular review of every department in the hospital. The intent is to objectively monitor the quality and appropriateness of patient care, to pursue opportunities for improvement, to resolve identified problems and to identify and evaluate any patterns of medical practices, professional performance and patient outcomes that are lower than the high-quality care achievable or that are unsafe or inefficient. Physicians, nurses, administrators and the Board of Directors are all involved in the process. Committees are assigned to set criteria for each area of the hospital and for the medical staff. On a monthly basis, all cases which do not meet the established guidelines are reviewed.

We feel it is important to make the public aware of these ongoing efforts to provide quality care. We cannot help society make informed decisions on health care until we provide them with this type of information.

Sincerely,

Kenneth R. Spoon
President

301 West Homer Street, Michigan City, Indiana 46360, 219-879-8511

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

The Administration and Board of Directors of Saint Anthony Hospital appreciates the opportunity provided us to review and comment on the mortality statistical information for 1986 Medicare patients treated at Saint Anthony Hospital.

We have analyzed the data and find them accurate for patients who died during hospitalization. We are unable to verify the actual deaths for those who were discharged alive and in good condition.

We agree the information can be useful to our efforts to improve the quality of care; however, we must call to your attention that the information is inconclusive as we cannot infer quality from death rate statistics. We would like to reiterate the view of the American Hospital Association that the statistics are flawed in that they do not adequately account for case mix and severity of illness.

I strongly encourage you to identify other analytical methods which will include the severity of illness and case mix index.

Sincerely,

Kevin D. Leahy
President

KDL/uw

St. Anthony Medical Center, Inc.

October 13, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Re: St. Anthony Medical Center
Hosp. No. 150126

Dear Doctor Roper,

Thank you for the opportunity to comment on HCFA Mortality Data prior to publication. This is an improvement in the process followed last year. Our comments will be as brief as possible, and will be directed in three areas:

I. Errors in the data.
II. Deficiencies in the methodology.
III. Use of the data.

I. ERRORS IN THE DATA

A. Errors in the Number of Mortalities

Each case on the listings was validated as being a patient of St. Anthony Medical Center. However, eight (8) mortalities were found which did not appear on the lists provided by HHS. Additionally, seven cases were coded correctly and did not fit into the 30+ day exclusion category. One case had an erroneous discharge status submitted. Exhibit A is a line listing of those patients. We have attempted to categorize these patients by diagnosis, but we have also included the UB-82 for each of these patients in Exhibit A so that you can categorize these patients yourself and include them in your model.

B. Errors in Date of Death

There were four cases where the date of death was erroneous and the patients actually died at the hospital. These cases are included on Exhibit B in a line listing format.

Telephones:
Merrillville (219) 738-2100
Crown Point (219) 663-8120
Lowell, Shelby & Cedar Lake (219) 374-9514

Main & Franciscan Road
Crown Point, Indiana 46307

C. Errors in the Medicare Hospital Population

As stated before, there were eight (8) errors in the number of mortalities. We were able to find these errors because you provided the patient names and because we were able to apply the 30+ day exclusion to our own listing of mortalities that is generated internally. We were unable to validate the total Medicare patients in your sample as the names of the live patients are not available. This is alarming since it is reasonable to assume that if there were errors in the number of mortalities, there may be a errors in the number of live patients.

We took our listing of live patients and compared that to your number of live patients. We eliminated all the multiple admissions of patients, counting only the most recent. When compared to the HHS number, we had 156 more patients. Your population represented only 91.1% of our total. Some of this difference may be represented by patients who only had one admission to our hospital, but subsequently had an admission at another hospital.It would be highly beneficial to have a listing of all patients in the model.

II. DEFICIENCIES IN THE METHODOLOGY

Patients in the sample include the number of Medicare beneficiaries treated in 1986. This includes patients admitted in 1985 but discharged in 1986, and patients admitted in 1986 but discharged in 1987. However, only the last admission of beneficiaries admitted more than once during the year are included.

This results in patients with more than one admission having the other admissions eliminated. These other admissions should be included, as they may have been completely separate diagnostic conditions that were treated appropriately. This results in a distortion of the data for those other diagnostic categories.

III. Use of the Data

The quality of care rendered in hospitals cannot be appropriately measured using the data that was generated in your reports. This information may be useful in providing limited focus to some quality assessment activities, but until additional measures are developed to deal with the severity and stages of illness and the individuality of "DNR" and "No Code" orders, judgements or comparisons about the quality of care in institutions cannot and should not be made and doing so can only lead to inappropriate conclusions by the general public.

Quality of care can only be evaluated after a thorough review of the individual medical records, which is conducted over a period of time. This process is occurring in our hospital and in the vast majority of hospitals across the country. Your data will be integrated into our quality assessment program and analyzed to assist us in making improvements.

Thank you again for the opportunity to comment on this data prior to publication.

Sincerely,

Stephen O. Leurck

Stephen O. Leurck
President

SOL:sjk

Attachments

IN 89.2

EXHIBIT A - ADDITIONAL MORTALITIES

HOSPITAL ID NUMBER - 150126

PATIENT ID NUMBER (MIC)	SURNAME (FIRST 6 LTRS)	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINCIPAL DIAGNOSIS	PRINCIPAL PROCEDURE
[redacted]		CA	74	F	02/03/86	02/12/86	02/12/86	1539	9229
[redacted]		HS	68	M	02/10/86	02/27/86	02/27/86	4275	
[redacted]		CE	74	M	09/06/86	10/05/86	10/05/86	4340	9607
[redacted]		TR	94	M	08/24/86	08/26/86	08/26/86	8604	
[redacted]		CE	74	F	09/12/86	09/18/86	09/18/86	4341	
[redacted]		CA	73	M	09/08/86	09/23/86	09/23/86	1983	9229
[redacted]		ME	86	M	06/18/86	06/19/86	06/19/86	2765	
[redacted]		HS	70	M	09/07/86	09/27/86	09/27/86	4101	3613

IN 89.3

EXHIBIT B – ERRORS IN DATE OF DEATH

HOSPITAL ID NUMBER – 150126

PATIENT ID NUMBER (MIC)	SURNAME (FIRST 6 LTRS)	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINCIPAL DIAGNOSIS	PRINCIPAL PROCEDURE
[redacted]		CA	79	F	05/16/86	06/03/86	06/06/86	1977	5419
		CA	84	M	07/24/86	07/25/86	07/26/86	1991	
		HM	69	F	09/02/86	09/22/86	09/23/86	4280	8963
		UN	80	M	04/21/86	05/06/86	05/07/86	9952	

4321 Fir Street
East Chicago, IN 46312
(219) 392-1700

St. Catherine Hospital

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington D.C. 20201

Dear Dr. Roper:

We appreciate the opportunity to review and respond to the Health Care Financing Administration's recent release of Medicare patients' mortality data. The Hospital recognizes and endorses the effort of the Health Care Financing Administration and those efforts of other reputable and qualified organizations and agencies such as, the American Hospital Association and Joint Commission on Accreditation of Hospitals, to promote consumer understanding and awareness of quality care indicators.

In carrying out our commitment to quality health care, St. Catherine Hospital with its Medical Staff has a long standing comprehensive Quality Assurance Program; one component being the peer review of all mortality data. As a physician, I am certain you recognize that mortality rates by themselves do not measure quality. Since the evaluation of quality care is an on-going process in our Hospital, we will consider the information generated by the Health Care Financing Administration as an additional frame of reference in our Quality Assurance Program, which uses data on all patients, in all circumstances, and takes into account the unique characteristics of our patients, our Hospital, and the community we serve.

Within the limitations of the model selected by the Health Care Financing Administration for its Medicare mortality study, the data representing St. Catherine Hospital is substantially accurate. We are encouraged that the experts in science, medicine, and research methodology are committed to someday providing not only health care providers but consumers with a validated assessment of the indicators of quality health care.

Meanwhile, St. Catherine Hospital and its Medical Staff will continue our practices and standards to ensure quality care to all of our patients.

Sincerely,

John R. Birdzell
Chief Executive Officer

JRB/oa

IN 90

Affiliate of ANCILLA SYSTEMS

St. Elizabeth Hospital Medical Center
1501 Hartford St. • P.O. Box 7501, Lafayette, IN 47903 • (317) 423-6011
Our business is life

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
ATTN: Harvey Brook, Director
Health Standards and Quality Bureau
P.O. Box 26684
Baltimore, MD 21207

RE: Mortality Data
St. Elizabeth Hospital
Medicare Number: 15-0003

Dear Mr. Brook:

Dr. William L. Roper, Administrator, Health Care Financing Administration (HCFA), stated in his September 21, 1987 letter to hospital administrators that, "In the public release of information, HCFA will make clear that the information on its own is not a complete measure of the quality of care at an individual hospital. While we believe that information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals."

We also counsel extreme caution in generalizing from this mortality data. The regional death rate, the hospital specialization in diseases likely to have the most serious outcomes, and the failure to include severity of illness measures or major risk factors such as lifestyle and family history are just a few of the critical factors needed to evaluate this data.

Because St. Elizabeth Hospital Medical Center is a regional referral center, nearly half of the patient days are from patients who reside outside of Tippecanoe County. The 1977 Central Indiana Health Systems agency publication, Health, Central Indiana, 1977 contains an analysis of mortality rates, by county, for specific disease processes. This analysis shows that for heart disease and cancer the seven counties surrounding Tippecanoe County have mortality rates that historically exceeded the state and national averages. While the reasons for this may only be found with epidemiological research, the phenomena must be kept in mind in evaluating any mortality rates from this area.

An important role of regional referral centers such as St. Elizabeth Hospital is to provide care needed by the most seriously ill patients. To that end, St. Elizabeth has developed highly specialized services to care for cancer, heart, pulmonary, and renal dialysis patients. The hospital and its medical staff continuously review statistics to monitor the care delivered here. The minimum number of cases needed to provide statistical significance is 30 so we will limit our comments to those diagnostic categories with number greater than 30.

The two causes of death which show the highest mortality rate, cancer and severe acute heart disease, represent diseases for which St. Elizabeth Hospital Medical Center is a regional referral center. The hospital's cancer program is accredited by the American College of Surgeons. We provide cancer chemotherapy services, the only radiation oncology services in mid-north Indiana, and a hospice program has been in place for 2 1/2 years.

Likewise, the hospital is the heart center for the region, providing a full spectrum of services including cardiac catheterization, angioplasty, open heart surgery, major vascular surgery, and cardiac rehabilitation.

Finally, it is important to note that the HCFA statistics leave out the key variables which are known to affect mortality such as genetic background, severity of illness, smoking history, and family support.

DATA VERIFICATION

The comparison of our records to HCFA's shows

	HCFA	St. Elizabeth
Medicare Admissions[1]	2247	3343
Deaths while inpatient[2]	238	281
Deaths after Discharge[3]	64	Unknown
Death Rate calculated with above data:	13%	8.4%

Comments on above figures:

[1]The discrepancy may reflect multiple admissions of individual beneficiaries; hospital sample may be more complete. We have verified that all patients on HCFA's list were admitted to this hospital.

[2]HCFA excluded deaths occurring in the hospital for Medicare patients staying more than 30 days. Hospital number includes all Medicare patients who died in the hospital in 1986.

[3]a. One patient listed as dying within 30 days of discharge in error. Patient number[redacted]ast admission to hospital began 3/27/87, more than 30 days after the end of 1986.

b. Patients numbers[redacted] died while inpatients, rather than after discharge, and are included in hospital deaths column. We cannot verify the remaining "deaths after discharge"; these patients left hospital alive.

Among our many concerns with the usefulness of these statistics is the inclusion of sepsis as a diagnosis category with its own mortality rate. Sepsis is a symptom or complication of another underlying disease. For this hospital, a majority of the cases in that category were cancer-related. A "sepsis" category distorts the relationship between mortality and the underlying disease.

Sincerely,

Paul E. Hess
President

PEH/sg

Saint Francis Hospital Center
1600 ALBANY STREET • BEECH GROVE, INDIANA 46107 • (317) 787-3311 • MEMBER GREATER INDIANAPOLIS HOSPITAL DISTRICT
PAUL J. STITZEL
PRESIDENT

Saint Francis Hospital Center (Medicare Provider Number 150033) Response to HCFA regarding Mortality Statistics
October 26, 1987

The purchasers of healthcare have a legitimate interest in data concerning quality of care. In reviewing such data, it should be noted that mortality statistics alone are not useful for drawing conclusions about quality. William L. Roper, M.D., Administrator of the Health Care Financing Administration (HCFA) was quoted in the August 17, 1987 issue of the Federal Register, "A difference between a hospital's actual and expected mortality rates cannot be definitely construed as reflecting an especially high or low quality of care."

Because quality of care is a primary concern at Saint Francis Hospital Center, there are numerous quality assurance programs in place at the hospital. These programs consider mortality figures as only one of numerous statistical characteristics which may trigger review of an area to determine if a quality problem exists. Medicare mortality figures should be reviewed in the context of the complexity of the case, diagnosis characteristics, patient acuity at the time of admission and many, many other factors.

The HCFA mortality figures are not as comprehensive in scope as those reviewed through the hospital's various quality assurance programs. As a matter of fact, it is difficult to determine the accuracy of the HCFA statistics from hospital records because of the differences in the review systems. HFCA has used the criteria "deaths within 30 days of admission," for medicare patients only, as as mortality statistic. Of the 495 deaths identified, HCFA has indicated that 60 patients died outside the hospital following discharge. Since there are no hospital records regarding these deaths, there is little way of knowing if these individuals died as a result of the condition for which they were hospitalized, from accidents, or from some other cause. Of the 435 deaths actually occurring at Saint Francis Hospital Center , 338 (78%) were viewed by HCFA as "high risk" patients. It should also be noted that 87 of the 435 patients (20%) charged to Saint Francis Hospital Center were so acutely ill that they died within a day of admission, 30 on the same day as they were admitted.

Although the individual mortality rates reported as attributable to Saint Francis Hospital Center are well within the ranges of "predicted mortality," we feel that the statistical model used to develop the ranges may be misinterpreted by many as being "an indicator of quality of care." Because the validity of the model has not been tested as an indicator of quality, the statistical information generated can do no more than raise questions for consideration by the various quality assurance programs within the hospital. Differences in data between hospitals should not be interpreted as a difference in quality of care.

The statistical model used by HCFA was designed to account for a hospital's unique mix of patients. A limited number of factors such as age, sex and admitting diagnosis were considered to develop a range of "predicted mortality." As a result, the data presented for St. Francis Hospital Center actually is designed to compare the hospital to itself, not to other hospitals, each of which have their own unique sets of data.

We recognize that the HCFA figures are being sent to hospitals as one more tool to use in evaluating quality of care. We welcome this information, along with information provided by a variety of other appropriate organizations: organizations such as the American Hospital Association and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which are investigating methods of evaluating hospital quality that rely on measures other than mortality rates.

In medicine today, "quality" is a measure of many factors, mortality rates being only one. Others include appropriate use of medications, appropriate surgical intervention, proper use of diagnostic equipment and technology, nutritional support, complications and secondary diagnoses, consultations, age, length of stay, etc. These and other indicators that contribute to the evaluation of quality can only be assessed by the individual audit of a medical record and a professional judgement of the appropriateness of diagnosis and treatment.

The philosophy of the Sisters of Saint Francis, which guides the hospital, challenges us to continually seek to provide the the best care possible. This philosophy focuses on compassion for those in need, respect for life and the dignity of persons, wellness and the prevention of illness, restoration to health and the acceptance of death as the final step toward wholeness.

ST. JOHN'S
HEALTH CARE CORP.
NEW TRADITIONS

October 26, 1987

Mr. William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Roper:

We at Saint John's Hospital have carefully reviewed and evaluated the mortality information about Medicare patients treated at Saint John's in 1986.

We find the statistical data sent to us to be reasonably accurate in regards to being able to identify the majority of all patients listed as having been admitted and discharged from Saint John's in 1986. Obviously, we cannot verify the death of each of these persons as we do not know of deaths that have occurred after a person has been discharged from Saint John's.

We do, however, have one significant statistic that we cannot verify nor agree with you on at all. That is the item listed as:

	Cases	Actual Mortality Rate
All Causes	2052	13%

As it is not clearly defined, we must assume this means all Medicare admissions for 1986. Our records do not agree with the statistic stated. It is very important to be sure this particular statistic is accurate as the percentage of actual mortality rate is based on this statistic.

I have attached two (2) different sources of statistical information that were prepared by parties outside Saint John's to support our contention that the statistics are not accurate.

The first are copies of the monthly report we receive from CPHA (PAS Professional Activity Study), Exhibit A, that states the number of admissions by payor source. You will note that Medicare and number of admissions are clearly visible on these monthly reports. Reports are for each month, January through December, 1986. The addition of these statistics for 1986 state that there were 3194 total Medicare admissions, not 2052 as your statistics state. This changes the actual mortality rate from the 13% you have stated to 8%. This is a significant difference to report to the public.

The second document is a copy of a letter, Exhibit B, sent to Saint John's by PeerView, the PRO, Peer Review Organization in the state of Indiana. Although the time period for the statistics stated in the letter differs from yours, the letter is valuable in supporting our position. Your time period is January through December 1986 and PeerView's is August 1986 through July 1987. This information includes only Medicare discharges from Saint John's and does not include deaths within 30 days of discharge. As you can see, there were 2973 Medicare discharges, 180 actual deaths, which reflects a 6% mortality rate. This again is a significant difference from your statistics and would be valuable to report to the public. Both of the Exhibits I have included with this letter show you that the actual mortality rate for Saint John's patients is significantly lower than what your statistics indicate.

I have also included a copy of your statistics with those that we have from the previously mentioned sources, CPHA and PeerView, to show you the statistics we have as compared to your statistics.

I do hope that you will review this information prior to the release of any mortality rates to the public. We ask that you revise your statistics for total admissions under All Causes to be the same as those reported in the CPHA Reports prior to any release.

Please feel free to contact me at 317-646-8105.

Sincerely,

James W. Moore

James W. Moore
Vice President

vcc: James H. Stephens, President and CEO, Saint John's Health Care Corporation

Enclosures

JWM/rl

CPHA

PAS Professional Activity Study
ST JOHN'S MEDICAL CENTER
ANDERSON IN

ACTIVITY REPORT

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SUMMARY BY PRINCIPAL PAYMENT SOURCE

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			SEX	PATIENTS BY AGE: 13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER		VARIABLE DATA		DEATHS: TOTAL	RATE	AUTOPSIED: NO.	AUTOPSIED: RATE	TOTAL PATIENTS OPERATED	
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY		PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
MEDICARE	254	2324	9.14				36	302	107	998	111	1024			16	6			94	3.

CPHA

PAS Professional Activity Study
ST JOHN'S MEDICAL CENTER
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ACTIVITY REPORT

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FEB 1966

SUMMARY BY PRINCIPAL PAYMENT SOURCE

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			SEX	PATIENTS BY AGE: 13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER		VARIABLE DATA		DEATHS: TOTAL	RATE	AUTOPSIED: NO.	AUTOPSIED: RATE	TOTAL PATIENTS OPERATED	
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY		PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
MEDICARE	283	2265	8.043				32	284	116	865	135	1116			26	9	2	8	88	32

CPHA

PAS Professional Activity Study
ST JOHN'S MEDICAL CENTER
ANDERSON IN

ACTIVITY REPORT

1 OF 1

MAR 1966

SUMMARY BY PRINCIPAL PAYMENT SOURCE

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			SEX	PATIENTS BY AGE: 13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER		VARIABLE DATA		DEATHS: TOTAL	RATE	AUTOPSIED: NO.	AUTOPSIED: RATE	TOTAL PATIENTS OPERATED	
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY		PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
MEDICARE	302	2503	8.29				32	302	145	1114	125	1087			19	6	1	5	97	32

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PAS Professional Activity Study
ST JOHN'S MEDICAL CENTER
ANDERSON IN

ACTIVITY REPORT

1 OF 1

APR 1966

SUMMARY BY PRINCIPAL PAYMENT SOURCE

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			SEX	PATIENTS BY AGE: 13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER		VARIABLE DATA		DEATHS: TOTAL	RATE	AUTOPSIED: NO.	AUTOPSIED: RATE	TOTAL PATIENTS OPERATED	
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY		PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
MEDICARE	283	2313	8.240				25	245	113	861	145	1207			28	10	2	7	88	33

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ST JOHN'S MEDICAL CENTER
ANDERSON IN

ACTIVITY REPORT

1 OF 1

MAY 1966

SUMMARY BY PRINCIPAL PAYMENT SOURCE

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			SEX	PATIENTS BY AGE: 13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER		VARIABLE DATA		DEATHS: TOTAL	RATE	AUTOPSIED: NO.	AUTOPSIED: RATE	TOTAL PATIENTS OPERATED	
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY		PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
MEDICARE	273	2275	8.333				36	390	111	915	126	970			10	4			73	29

CPHA

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ACTIVITY REPORT

Page 1 OF

JUN 1966

SUMMARY BY PRINCIPAL PAYMENT SOURCE

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			SEX	PATIENTS BY AGE: 13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER		VARIABLE DATA		DEATHS: TOTAL	RATE	AUTOPSIED: NO.	AUTOPSIED: RATE	TOTAL PATIENTS OPERATED	
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY		PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
MEDICARE	263	2080	7.942				30	226	116	878	117	976			18	7			79	24

Exhibit A

PAS Professional Activity Study

ST JOHN'S MEDICAL CENTER
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ACTIVITY REPORT

SUMMARY BY PRINCIPAL PAYMENT SOURCE

Page 1 OF 9

JUL 19

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			PATIENTS BY AGE								VARIABLE DATA		DEATHS				TOTAL PATIENTS OPERATED
				13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER						AUTOPSIED		
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS			TOTAL	RATE	NO	RATE	
1	2	3	4	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
MEDICARE	295	2612	8.95			27	255	130	1079	138	1278			15	S			96
	76	312	4.09	33	97	46	216							1	1			13

PAS Professional Activity Study

ST JOHN'S MEDICAL CENTER
ANDERSON IN

ACTIVITY REPORT

SUMMARY BY PRINCIPAL PAYMENT SOURCE

Page 1 OF

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CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			PATIENTS BY AGE								VARIABLE DATA		DEATHS				TOTAL PATIENTS OPERATED
				13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER						AUTOPSIED		
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS			TOTAL	RATE	NO	RATE	
1	2	3	4	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
MEDICARE	237	1995	8.46			37	441	94	692	106	862			14	6			71

PAS Professional Activity Study

ST JOHN'S MEDICAL CENTER
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ACTIVITY REPORT

SUMMARY BY PRINCIPAL PAYMENT SOURCE

Page 1 OF

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CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			PATIENTS BY AGE								VARIABLE DATA		DEATHS				TOTAL PATIENTS OPERATED
				13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER						AUTOPSIED		
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS			TOTAL	RATE	NO	RATE	
1	2	3	4	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
MEDICARE	236	1906	8.41	1	2	19	153	104	877	112	874			15	6			90

PAS Professional Activity Study

ST JOHN'S MEDICAL CENTER
ANDERSON IN

ACTIVITY REPORT

SUMMARY BY PRINCIPAL PAYMENT SOURCE

Page 1 OF

OCT 19

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			PATIENTS BY AGE								VARIABLE DATA		DEATHS				TOTAL PATIENTS OPERATED
				13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER						AUTOPSIED		
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS			TOTAL	RATE	NO	RATE	
1	2	3	4	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
MEDICARE	252	2027	8.04			33	239	95	676	124	1112			13	S	1	8	96

PAS Professional Activity Study

ST JOHN'S MEDICAL CENTER
ANDERSON IN

ACTIVITY REPORT

SUMMARY BY PRINCIPAL PAYMENT SOURCE

Page 1 OF

NOV 19

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			PATIENTS BY AGE								VARIABLE DATA		DEATHS				TOTAL PATIENTS OPERATED
				13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER						AUTOPSIED		
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS			TOTAL	RATE	NO	RATE	
1	2	3	4	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
MEDICARE	248	2058	8.30			24	141	102	850	122	1067			30	12			76

PAS Professional Activity Study

ST JOHN'S MEDICAL CENTER
ANDERSON IN

ACTIVITY REPORT

SUMMARY BY PRINCIPAL PAYMENT SOURCE

Page 1 OF

DEC 19

CLASSIFICATION OF PATIENTS / PRINCIPAL SOURCE OF PAYMENT	ALL PATIENTS			PATIENTS BY AGE								VARIABLE DATA		DEATHS				TOTAL PATIENTS OPERATED
				13 YRS AND YOUNGER		14 YRS TO 64 YRS		65 YRS TO 74 YRS		75 YRS AND OLDER						AUTOPSIED		
	TOTAL PATIENTS	TOTAL DAYS	AVG STAY	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS	PATIENTS	TOTAL DAYS			TOTAL	RATE	NO	RATE	
1	2	3	4	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
MEDICARE	268	2146	8.04			22	175	111	717	135	1254			18	7			84
	76	475	6.25	33	108	43	368							1	1			13

Exhibit B

PEERVIEW©

LEADERS IN HEALTH CARE COST MANAGEMENT

October 14, 1987

Ms. Ruth Walker
Medical Records
St. John's Medical Ctr.
2015 Jackson Street
Anderson, IN 46014

RE: Hospital Mortality

Dear Ms. Walker:

The PEERVIEW Quality Assurance Committee recently reviewed updated profiles for the quality objective, hospital mortality. The time period reviewed was August, 1986 ~~through July, 1987.~~ The data was based upon discharges occurring during this time period and identified in the PRO database as of August 23, 1987. Additional cases may be identified in the database after this date.

The analysis revealed there wre 211,049 discharges in the state with 14,043 deaths. The death rate for the year is 6.6%.

The following lists your hospitals data for the one year time period.

Pseudo Provider	Number of Discharges	Number of Deaths	Death Rate
99	2973	180	6.0%

Using the pseudo provider number, you will be able to locate your hospital on the attached bedsize group graph. Also find attached the list of patients included in the study. The first quarter, August, 1986 - October, 1986 was not reanalyzed as it is felt the database is 95% complete. Therefore, the second, third and fourth quarter patient lists are attached. Please use the first quarter patient list from the August 17, 1987 letter. As before, the admission and discharge dates are in computer system offset dates. A conversion table has been enclosed so you may convert these dates to actual calendar dates.

PEERVIEW encourages you to share this information with your medical staff. We are presenting this data to you merely for informational purposes only.

We will continue to review hospitals mortality rates on a quarterly

HOSPITAL = 150088 ST JOHNS HICKEY MEMORIAL HOSP ANDERSON IN

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE		RANGE OF PREDICTED MORTALITY RATES	CASES	Deaths	Rate
ALL CAUSES	2,052 ?	266 ?	13 %				
CA - CANCER	154	38	25 %	9 TO 16 %	154	38	25%
CE - CEREBROVASCULAR ACCIDENTS	94	31	33 %	17 TO 35 %	94	31	33%
EY - OPHTHALMOLOGIC DISEASE	4	0	0 %	20 TO 40 %	4	0	0%
GC - GASTROINTESTINAL CATASTROPHES	39	13	33 %	0 TO 100 %	39	13	33%
GI - GASTROINTESTINAL DISEASE	250	9	4 %	7 TO 34 %	250	9	4%
GU - UROLOGIC DISEASE	114	2	2 %	3 TO 10 %	114	2	2%
GY - GYNECOLOGIC DISEASE	29	0	0 %	1 TO 12 %	29	0	0%
HL - LOW-RISK HEART DISEASE	134	6	4 %	0 TO 87 %	134	6	4%
HM - SEVERE CHRONIC HEART DISEASE	151	33	22 %	2 TO 9 %	151	33	22%
HS - SEVERE ACUTE HEART DISEASE	74	28	38 %	14 TO 28 %	74	28	38%
ME - METABOLIC/ELECTROLYTE DISTURBANCES	65	16	25 %	26 TO 49 %	65	16	25%
OP - ORTHOPEDIC DISORDERS	120	3	3 %	10 TO 34 %	120	3	3%
PN - PULMONARY DISEASE	178	44	25 %	0 TO 7 %	178	44	25%
RN - RENAL DISEASE	21	1	5 %	12 TO 26 %	21	1	5%
SE - SEPSIS	16	4	25 %	6 TO 47 %	16	4	25%
TR - SEVERE TRAUMA	69	8	12 %	16 TO 62 %	69	8	12%
UN -		30		4 TO 20 %	1682	30	2%
		266			3194	266	8%

IN 93.5

PRO Report of 10/12/87 for 8/86-7/87
see attached copy.

Discharges	# of Deaths	Death Rate
2943	180	6.0 %

Exhibit C

Saint Joseph
HOSPITAL & HEALTH CENTER (Medicare # 150010)

October 26, 1987

W. L. Roper, M.D.
Health Care Financing Administration
Department of Health & Human Services
Baltimore, MD 21201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates.

Saint Joseph Hospital & Health Center is a 220 bed acute care hospital offering general medical and surgical services and specialty services that include renal dialysis, oncology, intensive care and cardiac rehabilitation. Our cancer care program, which is an area referral center, includes a hospice with a home care component.

The hospital-specific mortality data reported by HCFA has been carefully reviewed by hospital administration, the president of the Medical Staff and the directors of Quality Assurance and Medical Records. In particular, we have conducted an indepth review of the diagnostic category of cancer in which the mortality rate reported by HCFA was higher than the predicted rate.

We feel that, in order to avoid misleading the public, several flaws in the statistical model should be noted which are recognized both by hospitals and HCFA.

1. The model does not include measure of
   - how ill the patient was at the time of admission;
   - whether the patient was receiving treatment at home prior to admission;
   - whether the patient was transferred from a nursing home; and
   - whether the patient had a terminal illness.

2. The model does not take into account the mix of types of cancers within the overall category - an important flaw to note since some cancers have a higher risk of death than others.

Each of these flaws of the statistical model is significant to our hospital since we are a regional referral center for cancer care and a provider of hospice. Additionally, there is a significant difference between the actual number of cancer discharges from our hospital and the number reported by HCFA. Mortality rates based on the actual discharges are well

within the predicted range. While we understand that HCFA excluded some multiple admissions, this factor alone would not appear to explain their low number and needs further study to draw reliable conclusions.

At the time of this letter, we can call your attention to the following regarding the fifty-one Medicare cancer deaths identified in the report:

- The condition of 15 was compromised enough prior to their admissions that they required home health or nursing home care;
- Eighteen patients lived in areas outside Kokomo;
- All 51 patients were in the end stages of cancer or severly compromised by complications that included heart disease and kidney and respiratory failures. Death was an expected outcome or a significant possibility with all.

As an integral part of our hospital's quality assurance program and peer review process, every death in our hospital is evaluated to determine appropriateness of the care rendered that patient. And, as indicated above, we are investigating with our physicians and HCFA the significant discrepancy in the numbers of 1986 cancer discharges shown in our records compared to HCFA's.

Again, thank you for the opportunity to clarify our mortality data.

Sincerely,

Sister M. Martin McEntee

Sister M. Martin McEntee
President

gs

SAINT JOSEPH HOSPITAL MISHAWAKA

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Attached is the response for Saint Joseph Hospital, Mishawaka, Inc. regarding the mortality data recently provided by your office. We appreciate the opportunity to verify and comment on the data prior to its release to the general public.

Sincerely,

Cindy L. Seel, RRA

Cindy L. Seel, RRA
Director, Patient Information Services

CLS/jas

215 WEST FOURTH STREET · MISHAWAKA, INDIANA 46544 · (219) 259-2431
ANCILLA SYSTEMS AFFILIATE

In an attempt to verify and possibly foresee any misinterpretation of the HCFA mortality data, the following comments are offered:

HCFA has repeatedly indicated that the data are not, in themselves, measures of hospital performance. At best, they are indicators for further, more extensive, quality assurance review/studies. Saint Joseph Hospital supports this ideology and has always used death as an indicator for review. In fact, all deaths which occurred within the hospital were reviewed by physicians, not involved in the actual treatment, the appropriate Medical Staff service and the Medical Staff Quality Assurance Committee. This extensive review is conducted to monitor the physician's and hospital staff's performance in order to evaluate the appropriateness of the medical treatment provided. Mortality data, along with many other indicators, are used on a routine basis to monitor the quality of patient care.

The information received from HCFA was verified against the actual medical records and is accurate as far as admission dates, discharge dates, dates of death, age and diagnostic category. It is difficulty to verify information pertaining to deaths within 30 days of hospitalization since this information is not made available to the hospital.

When looking at HCFA mortality rates it is important to keep in mind the population from which the data are collected. These figures represent deaths in Medicare patients only. Age, unfortunately is a correlating factor in the probability of death. The average age of the 130 cases reviewed was 80-years old with 83% of the patients being 70 or more years of age. (The age ranged from 44 to 102.)

In addition, the majority of cases fell into a few diagnostic categories. Again these types of diseases, are unfortunately, associated with unfavorable outcomes including death. The majority of patients had one or more of the following diseases:

Cancer
Stroke
Pneumonia
Heart Disease
Stomach/Intestinal Diseases
Orthopedic Disorders

It should also be noted that almost all deaths within the hospital involved DO NOT RESUSCITATE ORDERS as a desire of the family and patient. Again this was primarily due to the terminal nature of the patient's condition.

In analyzing the data, there seemed to be no apparent trends among members of the Medical Staff. Three physicians accounted for 41% of the deaths. This would be expected since these physicians are Internists or Cardiologists and were involved in many of the cases in which the patient was in the Intensive care Unit. Again, this would typically be diagnostic categories such as strokes, pneumonia, cardiac conditions and some cancers. The remaining 59% were distributed amongst 20 physicians.

In summary, the mortality information is accurate, however, should only a portion of information used in the evaluation of the patient care provided by any hospital.

St. Joseph
MEDICAL CENTER

October 26, 1987

Wm. L. Roper, M.D.
Administrator
Health Care Finance Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: HCFA MORTALITY DATA

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for 1986. Since receiving the report, St. Joseph Medical Center staff has had the opportunity to review the data.

The data used by HCFA indicate that a total of 211 Medicare patients admitted to St. Joseph Medical Center died within 30 days of admission. The Medical Center was unable to verify the admissions of two patients listed in the HCFA data.

Of these 211 patients, 166 died while still a patient of the Medical Center, while 43 died after discharge. Medicare's sample includes 2,034 patients, while our own records indicate that 3,106 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries. Our own records also indicate that of the 209 Medicare patients who died within 30 days of admission, 42 were still alive at the time of discharge.

It is impossible for St. Joseph Medical Center to determine that the 42 patients that died within 30 days after discharge did in fact die, and the causes thereof, as information concerning death after discharge is not included in the patient's medical record. Review of those patients that died within 30 days after discharge indicate that 70% were discharged with a terminal condition.

700 Broadway
Fort Wayne, Indiana 46802
219/425-3000
ANCILLA SYSTEMS AFFILIATE

In none of the diagnostic catagories did the Medical Center's mortality rate fall outside of the range of the predicted mortality rate.

St. Joseph Medical Center is a licensed 487 bed tertiary care facility with a Medicare patient day utilization of 39.3%. The Medical Center is a regional burn center, receiving patients from a four state area. St. Joseph Medical Center also has an oncology service and extensive cardiac program, which includes cardiac catheterization, angioplasty and open-heart surgery that services as a referral center for a three state area.

The Medical Staff at St. Joseph Medical Center conducts an extensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this Medical Center.

Preliminary review of the mortalities involved in the study indicate that 65% of the patients were admitted through the Emergency Room. Of those patients admitted through the emergency room, 46% required basic or advanced cardiac life support prior to being transported to the Medical Center. In addition, 37% of those patients admitted via the emergency room came from nursing home facilities. Of the 12 patients that fell into the category of gastrointestinal catastrophes, 42% were cases where both family and physician agreed that no extraordinary life saving measures be utilized.

St. Joseph Medical Center takes pride in this effort to produce and publish meaningful and accurate information.

Sincerely,

Stanley A. Abramowski

Stanley A. Abramowski, Jr.
Executive Director

SAA:jcr

St. Joseph's
Hospital

We care...it's our way of life.

Leland Heights
Huntingburg, Indiana 47542
(812) 683-2121

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for the year of 1986. St. Joseph's Hospital is an 87 bed acute care facility whose case mix includes many patients with major medical and surgical illnesses. We also provide care in specialty units, i.e. ICU/CCU.

The Director of Quality Assurance along with the Director of Medical Records has validated that, with minor exceptions, the data is accurate. The hospital specific mortality data reported by HCFA has been carefully reviewed by: The hospital Administrator, Chief of the Medical Staff, Physician Chairman of Quality Assurance and Utilization Review. Even though we feel that mortality review is only one part of ongoing monitoring of quality care, our overall percentage of deaths is well within the expected ranges from HCFA.

The Medical Staff of St. Joseph's Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this facility. Review is always by individual cases, re: overall quality of care and is conducted in an on-going fashion, not just when statistics such as the mortality data are released.

Thank you for the opportunity to present this response.

Sincerely,

Sister Joanne Roark
Administrator

Theodore Wolff, M.D.
Chief of the Medical Staff

Oct. 24, 1987
Date

Saint Joseph's
Medical Center

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to provide input on the Medicare mortality statistics of 1986 provided by the Health Care Financing Administration. We find that overall, the HCFA data is accurate although it does not reflect the severity of illness of patients served.

Saint Joseph's Medical Center is a 339 bed acute care community hospital serving patients with major medical and surgical illnesses, over half of whom are covered by Medicare. We offer specialty care for persons with cancer, heart problems, orthopedic needs and kidney disease. We also have programs for pediatrics and rehabilitative medicine as well as general medicine and surgery.

You will note that the actual mortality rate from renal disease is 31%. This is reflective of our being the major kidney treatment center in Northern Indiana as well as Southwestern and lower Michigan serving patients who are in end stages of kidney disease and patients with acute kidney failure.

Physicians on our medical staff review every death in our facility for appropriateness of care. This system provides continuous feedback in the effort to meet and exceed quality care standards. These standards are established by external licensing and accrediting agencies as well as members of the medical staff consistent with recognized treatment regimens.

Thank you for the opportunity to present this response.

Sincerely,

Don Larimore

Don L. Larimore
President
Saint Joseph's Medical Center

DLL:lb

811 East Madison Street • P.O. Box 1935 • South Bend, Indiana 46634 - 1935 • (219) 237-7111

A Member of the Saint Joseph's Care Group and the Holy Cross Health System

SAINT
MARGARET
HOSPITAL

5454 Hohman Avenue
Hammond, Indiana 46320
(219) 932-2300
(312) 891-9305

October 26, 1987

Mr. Harvey Brook
Health Standards & Quality Bureau, 2-D-2
Meadows East Building
6300 Security Boulevard
Baltimore, Maryland 21207

Dear Mr. Brook:

Mortality rates for individuals at Saint Margaret Hospital and Health Centers fall within the predicted ranges for the Diagnostic Related Groups (DRG's) researched and released by the Department of Health and Human Services. However, in using this report, either to evaluate Saint Margaret Hospital and Health Centers alone or in comparison with others several important factors need to be taken into consideration.

The methodology employed by HCFA has the potential for generating misleading conclusions if used as the sole criteria for evaluating the performance of any health care institution. For example, randomly selected patients were grouped by DRG and ICD-9CM codes. This indicates the presence or absence of co-morbidity, and is at least a symbolic expression of how complex each individual case may be. However, it often fails to provide an accurate picture of acuity.

Nineteen of the randomly selected patients from Saint Margaret Hospital and Health Centers reported on were suffering from end stage renal disease. Although all were listed as "DRG co-morbidity" none were actually listed as end stage renal disease patients. Such reporting distorts a true picture of the mortality rate.

Similarly, the report included in its scope patients who expired within 30 days of discharge. These patients were factored into the morbidity statistics for the DRG for which they were admitted. Such an assumption cannot always necessarily be an accurate reflection of the true situation; i.e. it cannot be assumed that these patients in fact expired due to the same cause or causes for which they were admitted.

These are but two examples of the difficulties one faces in attempting to use the data in this report as the basis for constructing meaningful comparisons and conclusions.

This is not to say the report is without value. It serves to highlight areas that may warrant further investigation. But to rely on this report alone is not a viable course.

Sincerely,

Mark E. P. Parston

Mark E.P. Parston
Vice President
Marketing and Business Development

MEPP/es
cc: Sister Theresa Solbach
Sister Jane Marie Klein
Frank Mutsko
Dr. W.J. Sabo
American Hospital Association
Indiana Hospital Association

1500 South Lake Park Avenue
Hobart, Indiana 46342
(219) 942-0551

St. Mary Medical Center

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington D.C. 20201

Dear Dr. Roper:

We appreciate the opportunity to review and respond to the Health Care Financing Administration's recent release of Medicare patients' mortality data. The Hospital recognizes and endorses the effort of the Health Care Financing Administration and those efforts of other reputable and qualified organizations and agencies such as, the American Hospital Association and Joint Commission on Accreditation of Hospitals, to promote consumer understanding and awareness of quality care indicators.

In carrying out our commitment to quality health care, St. Mary Medical Center with its Medical Staff has a long standing comprehensive Quality Assurance Program; one component being the peer review of all mortality data. As a physician, I am certain you recognize that mortality rates by themselves do not measure quality. Since the evaluation of quality care is an on-going process in our Hospital, we will consider the information generated by the Health Care Financing Administration as an additional frame of reference in our Quality Assurance Program, which uses data on all patients, in all circumstances, and takes into account the unique characteristics of our patients, our Hospital, and the community we serve.

Within the limitations of the model selected by the Health Care Financing Administration for its Medicare mortality study, the data representing St. Mary Medical Center is substantially accurate. We are encouraged that the experts in science, medicine, and research methodology are committed to someday providing not only health care providers but consumers with a validated assessment of the indicators of quality health care.

Meanwhile, St. Mary Medical Center and its Medical Staff will continue our practices and standards to ensure quality care to all of our patients.

Sincerely,

John R. Birdzell
Chief Executive Officer

JRB/oa

ANCILLA SYSTEMS AFFILIATE

When You Need Some Special Care, We'll Be There.

St Mary's
Medical Center

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Please consider the following to be the response of St. Mary's Medical Center to mortality information forwarded by the Health Care Financing Administration in September, 1987:

The quality of the care given to our patients is, of course, of paramount importance to St. Mary's Medical Center. Processes designed to maximize the quality of care provided to our patients are welcomed. The information forwarded to us by the Health Care Financing Administration, despite its limitations, has been utilized toward that goal.

The charts of all patients who die at St. Mary's Medical Center are reviewed by the chairman of the involved medical staff department or his designee. Those reviews historically have not revealed any significant evidence of unexpected deaths or quality of care issues.

St. Mary's "actual mortality rates" were within the "predicted mortality rate" range in all 16 categories. In addition, our "actual mortality rates" were lower than the mid-range of the "predicted mortality rates" in 14 of the 16 diagnostic categories. Only gastrointestinal disease at 7% (3% to 10%) and severe acute heart disease at 49% (30% to 50%) were higher than the mid-range predicted rates. In addition, the overall mortality rate was less than the mid-range predicted rate.

The charts of all patients (50) dying in the severe acute heart disease category were reviewed by the physician responsible for medical staff quality assessment.

That review revealed that 68% of those patients were greater than 75 years of age and 42% were greater than 80 years of age.

Member — Daughters of Charity Health Systems Inc

Based on the clinical findings at the initial presentation, 26% of the patients would clearly have been expected to die and an additional 70% had a significant propensity for dying during the hospitalization. Only two patients died when the findings on admission would not have predicted a significant possibility of death. Further review of those two cases revealed no evidence of a quality of care concern.

Seven patients (14%) had out-of-hospital cardiac arrests prior to presentation. Twenty-five patients (50%) died within the first 48 hours of admission. Only four of the 50 patients did not have at least one of the following co-morbid conditions on presentation: anemia, diabetes mellitus, renal insufficiency, hypotension, heart block, congestive heart failure, pneumonia, cardiac arrest, or malignancy. These findings emphasize the severity of illness of the patients classified in this category.

In the severe acute heart disease category, St. Mary's actually had 150 patients admitted in 1986 as opposed to the 103 cases reported by the HCFA data. It should be emphasized that this correction changes the actual mortality rate at St. Mary's for Medicare patients with the ICD-9-CM codes falling in the severe acute heart disease category to 33%, not 49% as noted in HCFA's mortality information. This significant variation in mortality rates is created by the methodology of the HCFA analysis only taking into account the last admission of that year excluding all previous admissions. This variation and the wide range of predicted mortality rates for certain diagnostic categories, i.e., ophthalmologic disease (0% to 68%) and gynecologic disease (0% to 41%), limit the credibility of the HCFA analysis.

Sincerely,

Sister Juliana Kelly

Sister Juliana Kelly, D.C.
President

jlc

October 26, 1987

St. Vincent Hospital and Health Care Center

A Daughters of Charity Hospital

2001 West 86th Street
P.O. Box 40970
Indianapolis, Indiana
46240-0970
317-871-2345

William L. Roper, M. D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684 - 6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality data regarding Medicare patients treated at St. Vincent Hospital and Health Care Center during 1986. We are pleased to note that in spite of the high acuity level of our patient population, our rates fall within the predicted mortality ranges for all diagnostic categories listed.

We have not been provided the exact methodology utilized to prepare the mortality statistical analysis, however, we believe such an analysis should take into consideration the fact that St. Vincent Hospital and Health Care Center is a tertiary care, major referral center. Included among our services is a major Oncology Program, as well as a Hospice Inpatient Unit and Outpatient Program which provide supportive care to patients and their families throughout the death and dying process. Such programs have a major impact on the mortality rate reported for the cancer diagnostic category, as many patients are referred to us in their terminal stages.

In reviewing the three cardiac related diagnostic categories, it is of significance to note that the Indiana Heart Institute at St. Vincent Hospital has the largest Cardiology/Cardiovascular Surgery Program in the state of Indiana. As such, a large percentage of complicated, high acuity level patients are referred to St. Vincent from smaller cardiac programs which has an impact on our mortality in the cardiac diagnostic categories.

It is difficult to accurately compare the HCFA information to our own internal statistics as the data provided by HCFA include only those patients on whom claims have been processed. After adjusting our statistics to the HCFA formula (excluding multiple admissions, cases with a length of stay in excess of 30 days, etc), our reported total number of Medicare patients treated within this same time frame is significantly higher than that reported by HCFA. This discrepancy could have further impact on the accuracy of the mortality rates reported for the various diagnostic categories.

In reference to the reported post-hospital deaths, it is understandably a difficult and time-consuming process to validate the accuracy of this information as this type of data is not routinely included in our medical records. We do hope to have this in-depth analysis accomplished prior to publication of this information in December. From a preliminary investigation, we did note a few discrepancies which we wish to bring to your attention. According to the HCFA information, there were 708 deaths during this time period, of which 612 occurred during the patients' hospitalization and the remaining 96 followed the patients' discharge or transfer. According to our case specific analysis of the information provided, we report a total of 705 deaths of which 620 occurred within our facility and the remaining 85 following the patients discharge or transfer. It is also of interest to note that 52% of the post-hospital deaths involved patients who had been transferred from our facility to an extended care facility. As part of our utilization management program, transfers of patients to facilities providing an appropriate level of care are facilitated once it is determined that the patient will no longer benefit from acute care services.

As stated previously, we will continue to analyze this information as a part of our ongoing mortality review. While mortality is only one indicator of quality of care, it remains an important aspect of our Quality Review Program which continuously monitors the quality and appropriateness of care rendered to patients treated within our facilities.

Again, thank you for the opportunity to review and respond to this information.

Sincerely,

Bain J. Farris

Bain J. Farris
President

The Community Hospital

901 MAC ARTHUR BLVD. MUNSTER, INDIANA 46321

TELEPHONE 219/836-1600

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for Medicare patients seen by The Community Hospital for the period January 1, 1986 through December 31, 1986. After review of the data supplied to our hospital by the Health Care Financing Administration (HCFA), we would request that the following narrative clarification be included with these figures at the time of their release to the public in December of 1987.

Community Hospital is a 249 bed acute care facility providing a wide range of service to the community. Similar to other hospitals across the nation, our hospital continues to treat a patient population that is requiring more intensive care than ever before. Our hospital routinely treats a large number of patients requiring specialized services, including medical intensive care, coronary intensive care, and post-open heart recovery. As a result, publication of mortality rates must take into consideration that patients who are admitted are much sicker than in the past.

Since receiving the report from HCFA dated September 21, 1987, Community Hospital's administrative and medical staffs have had the opportunity to review this data in detail. The published data for Community Hospital in all categories is within the expected range provided by the Federal Government. Upon closer analysis, we feel that there are several additional factors that should be included in this analysis.

The HCFA statistical model eliminates from inclusion in the results multiple admissions by the same patient to the hospital. In other words, if a patient was admitted to our hospital eight times, only one admission is included in the total number of cases used to determine a hospital's mortality rate.

In the case of Community Hospital, HCFA reports an overall mortality rate of 13% based on 1,907 Medicare cases. However, according to our records, Community Hospital provided inpatient treatment to 2,880 Medicare patients for the period January 1, 1986 through December 31, 1986. Utilizing this information obtained from an actual count of medical records, the mortality rate for Community Hospital drops to 8.7% for all cases.

It is obvious that statistics cannot predict the quality of patient care services provided by any one hospital. However, a review of any patient mortality should be conducted to ensure that every treatment provided adheres to strict standards set forth by the hospital, the medical staffs, and the Joint Commission on Hospital Accreditation. All mortality in Community Hospital is reviewed for quality care by our medical staff on a monthly basis. This peer review evaluates the quality of care provided and the appropriateness of treatment. It is this review that assures Community Hospital patients receive the highest quality care in all circumstances.

Sincerely,

Edward P. Robinson

Edward P. Robinson
Hospital Administrator

EPR:bjb

DARREL J. SCOTT, FACHE
President

the king's daughters' hospital

October 16, 1987

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O.Box 26684
Baltimore, Maryland 21207

Dr. Roper:

In response to your letter of September 21, 1987 regarding statistics of mortality information about Medicare patients treated in our Hospital in 1986, these statistics have been carefully reviewed, specifically in the category of severe acute heart disease (myocardial infarctions, paroxysmal ventricular tachycardia, ventricular fibrillation and flutter, cardiac arrest, dissecting aneurysm, thoracic aneurysm ruptured, abdominal aneurysm ruptured, abdominal aneurysm non-ruptured, aortic aneurysm of unspecified site without rupture and cardiogenic shock).

Your data for the year 1986 indicate that our Hospital had 77 cases with a 57% mortality rate. Your data would seem to be incomplete in that our records indicate a total of 105 patients for the year 1986 with a mortality rate of 45.7%.

Attached is a listing of all patients in this category for the year 1986 to document the origin of our statistics.

Sincerely,

THE KING'S DAUGHTERS' HOSPITAL

Darrel J. Scott, FACHE
President

DJS:msd
Attachment

xc: Larry Williams, M.D.

1986 Death Report
(Heart Disease)

the king's daughters' hospital
P O BOX 447 MADISON INDIANA 47250 • 812 265-5211

(Hic) #	Age	Sex	Date of Admission	Date of Discharge	Date of Death
071	M		02/06/86	02/06/86	02/06/86
066	M		09/26/86	10/04/86	10/04/86
067	F		08/22/86	08/28/86	08/28/86
072	F		09/15/86	09/22/86	09/22/86
065	F		02/25/86	02/27/86	02/27/86
072	M		05/16/86	05/16/86	05/16/86
075	F		11/26/86	11/30/86	11/30/86
075	M		04/07/86	04/11/86	04/11/86
071	M		12/26/86	12/27/86	12/27/86
061	M		11/24/86	11/29/86	11/29/86
073	F		08/09/86	08/17/86	08/28/86
069	F		10/23/86	10/23/86	10/23/86
091	F		01/06/86	01/15/86	01/15/86
063	M		08/06/86	08/06/86	08/06/86
080	F		04/28/86	05/09/86	05/09/86
065	M		01/31/86	01/31/86	01/31/86
080	M		01/27/86	02/10/86	02/10/86
074	F		03/30/86	03/31/86	03/31/86
080	M		03/26/86	04/02/86	04/02/86
069	M		12/21/86	12/22/86	12/22/86
088	M		02/08/86	02/24/86	03/02/86
076	M		04/26/86	05/01/86	05/01/86
053	F		05/23/86	05/26/86	05/26/86
086	F		01/17/86	02/04/86	02/04/86
080	F		03/27/86	04/04/86	04/04/86
091	F		11/04/86	11/04/86	11/04/86
085	M		08/11/86	08/11/86	08/11/86
075	F		10/12/86	10/14/86	10/14/86
088	F		12/09/86	12/12/86	12/12/86
090	F		02/22/86	02/22/86	02/22/86
077	M		06/28/86	06/28/86	06/28/86
064	M		12/10/86	12/21/86	12/21/86
082	F		02/20/86	02/22/86	02/22/86
072	F		12/05/86	12/12/86	12/12/86
073	F		08/10/86	08/12/86	08/12/86
084	F		05/13/86	05/13/86	05/14/86
074	F		03/05/86	03/10/86	03/10/86
068	M		03/14/86	03/19/86	03/19/86
064	F		01/08/86	01/15/86	01/15/86
079	M		08/17/86	08/19/86	08/29/86
064	M		07/01/86	07/01/86	07/01/86
079	M		05/16/86	05/23/86	05/23/86
073	M		04/30/86	05/19/86	05/19/86

the king's daughters hospital
P.O. BOX 447 MADISON INDIANA 47250 • 812 265-5211

(Hic) #	Surname	Age	Sex	Date of Admission	Date of Discharge	Date of Death
		077	F	03/01/86	03/09/86	
		070	F	07/25/86	08/01/86	
		078	F	08/24/86	09/02/86	
		073	M	09/07/86	09/17/86	
		081	M	07/12/86	07/18/86	
		088	F	06/26/86	07/04/86	
		073	F	06/19/86	06/28/86	
		073	M	06/22/86	07/01/86	
		073	F	04/09/86	05/05/86	
		068	M	09/22/86	10/01/86	
		079	F	09/09/86	09/19/86	
		089	F	11/06/86	11/19/86	
		090	F	01/27/86	02/03/86	
		073	F	04/17/86	04/22/86	
		066	F	03/22/86	03/29/86	
		084	M	04/11/86	04/14/86	
		086	M	03/12/86	03/14/86	
		077	M	02/26/86	03/06/86	
		078	M	01/16/86	01/22/86	
		084	M	08/03/86	08/04/86	08/04/86
		090	F	05/17/86	05/22/86	
		067	M	05/26/86	06/01/86	
		068	F	04/14/86	04/22/86	
		070	M	04/11/86	04/21/86	
		073	M	04/10/86	04/21/86	
		078	M	08/22/86	09/01/86	
		065	M	07/06/86	07/16/86	
		073	M	08/09/86	08/17/86	
		085	M	08/05/86	08/12/86	
		076	F	08/11/86	08/19/86	
		078	F	06/09/86	06/11/86	
		077	M	06/30/86	07/11/86	
		097	F	04/16/86	04/25/86	
		078	M	04/30/86	05/ 4/86	
		074	M	04/15/86	05/02/86	
		076	F	11/29/86	12/08/86	
		078	F	11/26/86	12/04/86	
		080	F	10/20/86	10/26/86	
		080	M	11/17/86	12/01/86	
		070	M	8/28/86	09/13/86	
		070	M	12/10/86	12/19/86	
		072	M	08/08/86	08/15/86	
		073	M	04/11/86	04/28/86	
		077	M	06/23/86	07/06/86	
		073	F	01/16/86	02/03/86	
		060	M	03/31/86	04/06/86	
		073	M	12/28/85	01/12/86	

the king's daughters' hospital
P O BOX 447 MADISON INDIANA 47250 • 812 265-5211

(Hic) #	Surname	Age	Sex	Date of Admission	Date of Discharge	Date of Death
		085	M	07/26/86	08/04/86	
		077	M	03/11/86	03/15/86	
		070	F	04/23/86	04/23/86	
		077	M	04/25/86	05/02/86	
		079	M	12/25/85	01/17/86	
		061	M	11/24/86	11/29/86	11/30/86
		068	M	01/26/86	02/11/86	
		082	F	11/21/86	12/16/87	12/16/86
		085	M	01/28/86	02/08/86	
		072	F	05/14/86	05/22/86	
		079	F	07/18/86	07/29/86	
		065	M	08/25/86	08/25/86	
		090	F	12/22/85	01/10/86	01/10/86
		040	M	07/16/86	07/25/86	
		048	M	04/14/86	04/17/86	

the lutheran hospital of fort wayne, inc.

3024 FAIRFIELD AVENUE • PHONE 458-2001 • FORT WAYNE, INDIANA 46807

October 26, 1987

Mr. Harvey Brook
Health Standards Quality Bureau
Meadows East Building
6300 Security Blvd.
Baltimore, MD 21207

Subject: Mortality Statistics

Dear Mr. Brook:

The following information for The Lutheran Hospital of Fort Wayne, Inc. is to be attached to the Hospital Specific Report for the period October 1, 1984 through September 30, 1986, prior to public disclosure.

Lutheran Hospital of Fort Wayne, Inc. is a 420 bed acute care facility whose case mix includes many patients with major medical and surgical illnesses. The Lutheran Hospital of Fort Wayne is a full service community hospital offering care in the specialty areas of heart disease, including heart transplantation, kidney disease, orthopedics, oncology, the neuro sciences as well as general medicine and surgery.

The medical staff at the Lutheran Hospital of Fort Wayne conducts an intensive review of the medical management and overall care of every patient who dies at this facility. Mortality review is an ongoing process of the Quality Assurance program and combined with peer review is an integral part of monitoring the health care delivery system at this hospital.

The hospital-specific mortality data reported by the Health Care Financing Administration (HCFA) has been carefully reviewed by: the management personnel including the Director of Patient Care Assessment and Director of Medical Records. In our evaluation, it was noted that this year's methodology incorporates different diagnostic categories and a more sophisticated formula which precludes both comparison with last year's information or comparison between hospitals. However, we consider this information to be useful in conjunction with our ongoing intensive individual case review process. It is in individual case review that the quality of care is thoroughly evaluated. However, aggregate statistics, such as the mortality data, are useful in suggesting areas for quality review.

The medical and hospital staff, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care. This review practice reflects The Lutheran Hospital's continuing mission to identify opportunities to improve patient care.

Sincerely,

Frederick H. Kerr, President

Dr. Cottrell, President Medical Staff

/hjd

THE METHODIST HOSPITALS

Northlake Campus
Corporate Office
600 Grant St.
Gary, IN 46402
(219) 886-4000

Southlake Campus
8701 Broadway
Merrillville, IN 46410
(219) 738-5500

Provider #15-0002 Provider #15-0132

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Avenue South West
Room 314G
Washington, D.C. 20201

Dear Dr. Roper:

In response to your September 21, 1987 communication regarding the intended release of mortality rate data for 1986, please note the following:

The Methodist Hospitals serve as a regional referral center for communities throughout Northwest Indiana. Diagnostic and treatment capabilities which attract physicians and their patients to the hospital include:

Cancer Center
.Oncology Units
.Radiation Therapy
.Diagnostic Capabilities
.Mammography
.Hemotherapy

Gerontology
Support and education for caregivers through clinical specialist nurses

Cardiac Services
.Cardiac Rehabilitation
.Cardiac Catheterization
.Open Heart Surgery
.Coronary Angioplasty

Imaging Services
.Full Service Diagnostic
.Radiology Services (CT Scan, X-Ray)
.Magnetic Resonance Imaging Services
.Active Interventional Radiology

Emergency Medical Services
.Trauma Alert Program
.Regional Coordination Center for emergency medical serivces for 7-county area
.Intensive Care/Coronary Care Units

Renal Services
.Inpatient/Outpatient Services
.Dialysis

Neuro Behavioral Medicine
.Adult Psychiatry
.Child and Adolescent Psychiatry
.Alcoholism and other Chemical Dependencies

Rehabilitation Services
Since 1971, we have been accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), with a full complement of Physical Therapy, Occupational Therapy, Speech and other Rehabilitative Services.

NeuroScience Units
Neurosurgical services

Specialty Health Centers
.Eye
.Pulmonary
.Lupus
.Arthritis

All patients listed for the Northlake and Southlake Campuses with the exception of one, were patients who had been hospitalized at the Methodist Hospitals during the year 1986.

The hospital has a well-established quality assurance process which includes mortality review. All deaths are reviewed from a nursing and physician standpoint to evaluate the quality of patient care management.

It is significant to note that the leading causes of death are consistent with those of the nation and the state. The leading causes of death for the State of Indiana in 1985 were diseases of the heart (1), cancer (2), cerebrovascular disease (3), and chronic obstructive pulmonary disease (4). In reviewing the data of The Methodist Hospitals, the leading causes of death are the same - consistent with both state and national data.

The HCFA model considers several patient variables in its calculation of the data presented, including age, sex, principal diagnosis, additional diagnoses and numbers of prior hospitalizations. Upon review of The Methodist Hospitals data, it was found that a significant number of patients, approximately 50%, had one or more significant co-existing conditions in addition to that condition which necessitated hospitalization. This is consistent with the hospital's role as a regional referral center for cardiovascular disease, cancer, renal disease, pulmonary disease, etc.

Further attesting to the severity of illness of patients treated at The Methodist Hospitals is the primary admission source, the emergency room. More than 60% of the Medicare patients included in the mortality data presented at the emergency room and were determined to require inpatient treatment. Also, we receive many elderly patients from area nursing homes when healthcare requirements necessitate an acute care setting.

It is the philosophy of the hospital to meet the healthcare needs of the community, ranging from those who are ambulatory to the critically ill. The increasingly aging population of the Northwest Indiana communities allows us to serve a significant percentage of Medicare patients - 23.9% of all Lake County residents ages 65 or older.

Because the data presented for each hospital is hospital - specific (considering the specific patient population of the hospital and hospital services provided), it will be of little value to consumers to compare hospitals on the basis of the data presented. Many factors of course, enter into an assessment of hospital performance, of which mortality is but one.

Until the parameters to be used by consumers, hospitals and Peer Review Organizations for the determination of the presence or absence of quality care are defined, the assessment of quality from models currently in use is limited to inference rather than measurement. Thus, Medicare recipients are encouraged to discuss the mortality data with their physicians for a better understanding of factors influencing quality of care rendered in a hospital setting.

Thank you for the opportunity to comment.

Sincerely yours,

John H. Betjemann
President

Hakam Safadi, M.D.
President
Medical Staff

JHB/HS/dg
0050G/1-3

UC
MH
UNION CITY MEMORIAL HOSPITAL • 900 NORTH COLUMBIA STREET • UNION CITY INDIANA 47390
Medicare # 150085

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

In response to the mortality figures which were released for our facility regarding medical admissions for calendar year 1986.

I will confine my responses to the two areas in which our statistics were outside predicted mortality rates.

Those two were cancer and severe acute disease.

In regards to our mortality figures for cancer:

1. Only two cases were surveyed, this is not an adequate number for statistical significance.

2. Both patients were end-stage terminal cancer patients who were referred back into a hospice type situation.

3. Their average L.O.S. was 1.5 days.

4. The computations make no adjustment for lack of adequate statistical pool, or severity of illness.

In regards to our mortality figures on severe acute heart disease:

1. Again our survey only included 6 cases which is not a statistically significant group.

2. One third of those surveyed died post-hospital stay.

3. Average age of patients, 79 years of age.

4. No allowance is made for the importance of disease staging or the involvement of other chronic debilitating diseases.

PHONE: (317) 964-6222

5. No consideration is given to use of living will or "right to die" paths that many patients or families opt to pursue.

I feel that the accumulation of data is very important and helpful, but would be much more valid of other indicators were used such as age, severity of illness, personal wishes and length of stay.

Roger L. Holloway,
Administrator
Union City Memorial Hospital

October 26, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
Department of Health and Human Services
Attn: HSQ-148-GNC
Washington, D. C. 20201

Dear Dr. Roper:

Union Hospital, Inc. would like to take this opportunity to provide comment on the 1987 Mortality Data Release by HCFA. It is our understanding that this information will be made available and published with our Mortality Data when it is released.

Union Hospital is a 354-bed acute and specialty care referral hospital for the area. Approximately 42% of our admissions are of an emergency nature or are transferred from another facility. Additionally, 53% of our patient days are for Medicare patients. More specifically, 42% of our patient days are for patients who are 70 years of age or older.

Union Hospital, its Board and Medical Staff have always held quality patient care to be of primary importance. Our Medical Staff reviews all patient care provided at the Hospital. This Quality Assurance process involves the use of numerous indicators, including mortality data, in order to identify any problems in patient care. Additionally, all patient deaths occuring at Union Hospital are screened by applying criteria developed and approved by the Medical Staff. Any chart not meeting this criteria is reviewed by the appropriate Medical Staff Department to identify any deficiencies in medical management. These ongoing reviews have not revealed any pattern of inappropriate care.

It is important to understand that no single indicator, such as mortality data, can accurately measure quality care. From our experience, we realize that it is extremely important to consider all aspects of patient care and not to place excessive emphasis on any particular indicator. Although our overall mortality rate is within the predicted range, we recognize that this indicator by itself, is not a reliable measure of the quality of care provided at Union Hospital or any other Hospital for that matter.

Single indicators, such as the mortality data being presented, are limited in their use. As with any statistical information, it is important to understand the methodology in order to interpret the results. This mortality data is an example of the inherent shortcomings of the methodology used in its calculation. It is severely limited by its inability to measure such clinically pertinent factors as severity-of-illness upon admission and pertinent demographic information.

1606 North Seventh Street ·Terre Haute, IN 47804-2780 ·(812) 238-7000

While the mortality data does provide information that can be trended, and can be used to help direct and assist us in our ongoing patient care evaluations, it is not by itself a reliable or even accurate measure of the care provided. It may be considered only as a part of a much broader process.

We appreciate the opportunity to comment on the mortality data.

Sincerely,

UNION HOSPITAL, INC.

Frank Shelton

Frank Shelton
President

FS/rab

UNIVERSITY
HEIGHTS
HOSPITAL

1402 East County Line Road South
Mailing Address: P.O. Box 27010
Indianapolis, Indiana 46227
Telephone: 317 887-7000

George W Poor
President
Telephone 317 887-7111

October 9, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
200 Independence Avenue Southwest
Washington, D.C. 20201

Dear Dr. Roper:

We are in receipt of the information submitted to us by Department of Health & Human Services, division of Health Care Financing Administration, dated September 21, 1987. After review of our specific data, I would like to offer for you the following, brief comments.

In the abstract, this data is meaningless because a) they don't reveal the condition of the patient upon admission, b) they don't consider familial history or genetics, c) they don't consider complications or interventions, d) they don't consider co-morbid conditions, e) they don't consider what occurred to the individual after discharge and, therefore, they are indicative of nothing meaningful except to say that the individual expired.

While our hospital fell well within the median of all categories listed, this data could conceivably be misinterpreted if the above factors are not taken into consideration.

I would suggest that in the future HCFA not disclose this information to anybody due in part to the fact that misinterpretation could be damaging to the entire healthcare system of the United States.

Sincerely,

George W. Poor
President

GWP:rm

cc: T. Wisler, M.D.
Chief of Medical Staff

Michael Dellen
Chairman, Board of Director

WARRICK HOSPITAL
1116 Millis Avenue
Boonville, Indiana 47601
(812) 897-4800

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Thank you for the opportunity to review and comment on the mortality statistics prior to their publication.

The Board of Directors, Administration, Medical Staff, and employees of Warrick Hospital all share a commitment to providing quality care to all of our patients. This commitment is evidenced by the involvement of each group in the on-going review of various facets of care, including (but not limited to) the review of all deaths for the appropriateness and quality of the services provided.

While mortality statistics may be useful in suggesting areas for further study, Warrick Hospital shares AHA's view that these statistics, in isolation, cannot be considered indicative of either high or low quality care. Only in-depth review of individual cases by trained, competent medical professionals can determine whether quality care was provided. We are hopeful that better measures can eventually be developed to provide the public with the desired information.

Although we review all deaths concurrently as a part of our Quality Assurance Program, here we will only be addressing those deaths listed in the "Severe Chronic Heart Disease" (SCHD) category. This category includes patients discharged with congestive heart failure, rheumatic (congestive) heart failure, cardiomyopathies, and hypertensive heart disease with congestive heart failure. The listed mortality rate of 47% is within the predicted range of 10 to 49%; however, we wish to comment on this category to illustrate a problem which is inherent in the methodology.

The data used by HCFA indicate that a total of 19 Medicare patients were discharged from Warrick Hospital in the SCHD category. Of these 19 patients, nine (9) died within 30 days of admission. These nine patients include seven (7) who died while a patient at Warrick Hospital, and two (2) who died following discharge.

According to our records, we had 38 Medicare cases of congestive heart failure discharged during 1986. Presumably the difference between the HCFA data and ours is due to repeat admissions for some of the patients. While we

acknowledge that repeat admissions are excluded by HCFA's methodology, we feel that it should be noted that our Medicare mortality rate is 23.7% for this category when based on actual discharges.

Despite the category's heading of "Severe **Chronic** Heart Disease," seven (7) of the nine (9) cases were specified as having "acute" congestive heart failure or edema. Five (5) of the patients and/or their families requested "no code" status. One patient had been hospitalized for an acute myocardial infarction the month prior to the reported admission for CHF, and two additional patients had discharge diagnoses that included "possible myocardial infarction" (which were not provable due to the deaths occurring shortly after admission).

No patterns were found other than the advanced ages of most of the nine (9) patients: 96, 92, 89, 84, 83, 80, 80, 77, and 70 years. The average age at the time of death was 83.4 years. The deaths were fairly evenly distributed among the four physicians who admit most of our Medicare patients, and the number of deaths attributable to each physician was in line with the volume of his practice.

When originally reviewed through our Quality Assurance Program, each of the seven (7) in-house deaths was considered to have been appropriately treated. **All** discharges, regardless of payment category, are reviewed against discharge screens to monitor for possible premature discharges. At present we have no mechanism for reviewing discharged patients who die shortly after discharge; however, we are currently developing such a mechanism to assure that we do not miss any potential quality problems, such as a death that results from a premature discharge.

Again, we appreciate the opportunity to comment on this data and are looking forward to further improvements in development of measures of quality.

Sincerely,

Sister Renée Rose

Sister Renée Rose, D.C.
Administratory/CEO

SRR/th

Welborn baptist hospital
401 S.E. Sixth Street · Evansville Indiana 47713 · (812) 426-8000

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Review Information
P.O. Box 26684
Baltimore, Maryland 21270

RE: 1986 Mortality Statistics--Hospital 150025

Dear Doctor Roper:

Thank you for the occasion to append the 1986 mortality statistics describing the Medicare population treated at Welborn Baptist Hospital.

Although our overall mortality rate of 11% falls at the midpoint of predicted range specific to Welborn Baptist Hospital, we feel that mortality statistics alone, without account of the severity of illness of the individual patients within a disease category, is too incomplete a criterion to be used in assessing the quality of care provided by an institution.

We do welcome the opportunity to amend the following categories:

In the category of SEVERE AND ACUTE HEART DISEASE, there were two patients listed who were not cardiac patients, but who experienced the traumatic rupture of their abdominal aortas, a condition associated with a high rate of mortality. Both patients were taken immediately to the operating room upon their arrival at the hospital, both expired within their first hospital day.

Deleting these two cases reduces the mortality rate of the high risk category of severe and acute heart disease to 38%.

The one patient in the category of ORTHOPEDIC DISORDERS, had previously been hospitalized for a repair of her fractured hip. She was released to an area nursing home in good condition, but two weeks following her hospitalization, died of natural causes unrelated to her hip.

Deleting this case reduces the mortality rate of the category of orthopedic disorders to 0%.

William Roper, M.D.
October 23, 1987

One quarter of the patients on this list were discharged from the hospital alive and in a general condition healthy enough to meet the rigid criteria set by Medicare to assure that patients are not discharged from the hospital prematurely. These patients are included in the mortality statistics as they died within one month of hospitalization, without distinction of discharge to nursing home, hospice or home.

Welborn Baptist Hospital supports a full service emergency and trauma center as well as the only air ambulance servce in our Tri-State region. Fifty-five percent of the critically ill patients we transport from the region are eventually admitted to our hospital. Although we do fall within your predicted range of mortality for severe trauma, we question that the range 3% to 18% is far too low a range for severe trauma.

As a part of our Quality Assurance Program, the Welborn Baptist Hospital Medical Staff conducts an ongoing review of every death occurring at this facility. This monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

Sincerely,

Marjorie Z. Soyugenc
President
Welborn Baptist Hospital

PHONE 219 / 824-3210

THE WELLS COMMUNITY HOSPITAL
1100 SOUTH MAIN STREET
BLUFFTON, INDIANA 46714

October 23, 1987

Dr. William L. Roper
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear. Dr. Roper:

I am writing you in response to your communication regarding the public release of hospital specific mortality data for 1986. Our staff has reviewed the data as well as the actual medical records for the cases identified. Although we have some concerns about the statistical methodology utilized, you should be aware that all hospital deaths are reviewed by a committee of the medical staff on a timely basis. This Medical Staff Committee Review has been a policy of our facility over the years.

Upon the evaluation of our data, we noted that a significant number of cases involved patients over the age of 80. One additional area noted in our review of data and charts was that many of the patients expired outside the hospital, either at skilled nursing facilities, or even at home. Many of the patients were at home utilizing services of our Home Health Care Agency allowing the family to be with the patient during his/her final days.

Quality Assurance is an essential function within our institution. Mortality data is only one factor of quality care. We as an institution combine numerous factors which include mortality data to develop a full specturm of information to determine the quality of services provided.

Sincerely,

Martin Braaksma
Administrator

MB/je

WESTVIEW HOSPITAL

October 22, 1987

Westview Hospital
Indianapolis, Indiana
Provider 150129

RESPONSE TO MEDICARE MORTALITY INFORMATION

Westview Hospital routinely reviews the outcome of patient treatment rendered in this institution in order to monitor and improve the quality of care rendered to all patients and accepts the responsibility to the public to provide high quality care in a cost effective manner. As part of this ongoing quality review, Westview supports this attempt by HCFA to assist in the effort.

With respect to the data collected and processed by HCFA, the following comments are offered:

1. There is an error in the date of death of one patient included in the data.

2. The attempt to apply statistical methods to a fixed number of disease categories has resulted in wide ranges of expected outcomes in several cases which implies insufficient data to reliably fix the range of expected outcomes. Because of the relatively small number of deaths in some disease categories, the results are unreliable indicators of the expected outcomes.

3. Because the ability of the statistical model to identify differences in quality has not been tested, there is great concern about the public use of the published results.

4. The results, taken alone, **do not measure quality of care.**

5. Factors other than those considered contribute to the outcome of care rendered in this or any institution in either a positive or negative manner. Some of these are: the number of indigent patients served who have more severe health problems than other sectors of the population; genetics; presence or absence of a family support system; severity of illness; whether the institution is a teaching hospital; whether the institution is a tertiary referral center; etc.

AN OSTEOPATHIC INSTITUTION
3630 GUION ROAD ■ INDIANAPOLIS, IN 46222 ■ (317) 924-6661

6. The inclusion of deaths occurring within 30 days of admission results in the inclusion of patient deaths which occurred outside the hospital for which the death was unrelated to the care rendered in the hospital.

7. For a small institution such as Westview, the inclusion of only Medicare patients results in an unreliably small statistical model. Hence, the probable ability to replicate results is questionable.

Summary

Westview Hospital applauds this effort to attempt to identify possible areas for further study of quality of care. However, Westview believes the methodology falls short of providing data which may be reliably used to evaluate the quality of care being rendered in any individual institution generally and for Westview Hospital in particular. Many factors influencing the quality of care are unable to be measured by the model being used by HCFA. Nevertheless, the data may be of value when used in conjunction with the ongoing quality of care evaluations routinely conducted by Westview Hospital. The data, however, taken alone do not accurately or reliably indicate the quality of care being rendered at Westview Hospital. Any attempt to draw general conclusions on the data alone will lead to inaccurate conclusions.

Submitted by
James F. Knopp, President and Administrator

WHITE COUNTY MEMORIAL HOSPITAL
1101 O'Connor Boulevard, Monticello, Indiana 47960 (219) 583-7111

from the office of the Executive Director

October 26, 1987

Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Sir:

The data used by HCFA indicate that a total of 477 Medicare patients were admitted to White County Memorial Hospital during calendar year 1986. Of these, 52 died while still patients in the hospital, while 22 died within 30 days of admission but after discharge from the hospital. Our own records indicate that 775 Medicare admissions occurred in 1986. Presumably the discrepancy reflects HCFA's not counting multiple admissions of individual beneficiaries. There is no way to verify HCFA's data pertaining to the number of Medicare patients treated.

The hospital records indicate that of the 52 patients who died, two patients on HCFA's list were never patients at WCHM and two Medicare patients who died here were not listed by HCFA. The hospital has not been able to determine if the 22 patients dying after discharge did so within 30 days of admission. Information concerning death occurring after discharge is not included in the patient's medical record.

Without the detailed information utilized by HCFA in computing the predicted mortality rates, it is impossible to verify the accuracy of the diagnostic or other data used in their analysis.

We also found one patient listed in the diagnostic category UN who should have been listed in diagnostic category GI.

It should be noted that 31 of the 52 patients who died in the hospital had significant comorbid conditions that most likely contributed to their death.

The corrections stated above change the mortality rate in the following categories to:

Diagnostic Category	Cases	Mortality Rate
CE	21	43
GI	50	4
HM	23	26
OP	18	0

Even with the corrections, the hospital's actual mortality rates fall well within the predicted mortality rates as published by HCFA.

The HCFA data themselves are not measures of hospital performance. Under no circumstances should they be used as the basis for judging the quality of care provided by different hospitals.

Sincerely,

Ed Pfeiffer

Ed Pfeiffer, Administrator

co/jmh

WISHARD
MEMORIAL
HOSPITAL
INDIANA UNIVERSITY
MEDICAL CENTER
1001 West 10th Street
Indianapolis, Indiana 46202
317/639-6671
"Division of Hospitals . . .
The Health and Hospital
Corporation of Marion County."

October 28, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
The Administrator
Washington, D.C. 20201

Dear Dr. Roper:

The Wishard Hospital staff is appreciative of the opportunity provided by HCFA to review and comment on Medicare mortality data for 1986. The data provided was researched and discussed jointly by the medical and administrative staff. Although we were pleased that our mortality rate of 11%, as assessed by HCFA, was well within the acceptable range of 7 to 14 percent, there are comments and observations we feel obligated to make.

The areas and items of concern are:

1. Wishard is an urban, public, teaching hospital with a significant number of black patients. The staff believes that this fact has impact on how our data should be interpreted, since there is verifiable clinical data that supports a difference in disease processes along racial lines.

2. Wishard provides services to a disproportionate share of the economically disadvantaged residents in the area. Once again, there is evidence that suggests diet, environment, and available support systems can influence clinical outcomes.

3. Many elderly patients that we serve have significant co-morbid disease processes that exacerbate the patient's clinical prognosis. The above two items of race and socioeconomic status have a significant influence on co-morbid circumstances.

4. The possible negative interpretation of the aggressive admission, discharge and treatment of the elderly, multiple diseased patient may be problematic. Because of the routine, long-term involvement with admitted patients through the hospital clinics, the medical staff is well versed in the illnesses and prognosis of most patients.

Therefore, when a disease or combination of diseases project a terminal outcome, and the patient's condition is appropriate for discharge, attempts are made to place the patient in a nursing home or to return them home with support of a visiting nurse. This explains to a certain extent why HCFA identified 50 of 168 deaths as occurring outside the hospital.

5. A review of the 50 deaths after discharge revealed that there was disparity in the date of death in seven cases. Our records show that these patients died at the hospital.

6. Of the 50 cases that received significant review, because the patient died after discharge, 19 were identified as terminal while an additional 15 had significant comments concerning complications due to major co-morbid situations at discharge.

I hope the items and concerns raised herein are constructive, and help to refine the HCFA data base. The intent was to suggest major issues from our prospective. I hope we have made a contribution to your effort.

Sincerely,

William T. Paynter, M.D.
Hospital Director

WTP/b

Wirth Osteopathic Hospital

HIGHWAY 64 WEST 812-749-6111

OAKLAND CITY, INDIANA 47660

October 7, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Hospital Mortality INformation
P. O. Box 26684
Baltimore, Maryland 21207

Hospital Provider No. 15-0123

Dear Dr. Roper:

In reviewing the list of deaths for our hospital, I find that only 12 out of the 27 listed actually expired in our hospital.

If you wish any further information, please feel free to contact me.

Sincerely,

Marie Buck

Marie Buck, Director
Medical Records Department

Iowa

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall: Number of Patients	Overall: Actual Mortality Rate/Percent	Overall: Range of Predicted Mortality Rate/Percent	High Risk Diagnostic Categories: Cancer: Number of Patients	Cancer: Actual Mortality Rate/Percent	Cancer: Range of Predicted Mortality Rate/Percent	Stroke: Number of Patients	Stroke: Actual Mortality Rate/Percent	Stroke: Range of Predicted Mortality Rate/Percent	GI Catastrophes: Number of Patients	GI Catastrophes: Actual Mortality Rate/Percent	GI Catastrophes: Range of Predicted Mortality Rate/Percent	Severe Chronic Heart Disease: Number of Patients	Severe Chronic Heart Disease: Actual Mortality Rate/Percent	Severe Chronic Heart Disease: Range of Predicted Mortality Rate/Percent	Severe Acute Heart Disease: Number of Patients	Severe Acute Heart Disease: Actual Mortality Rate/Percent	Severe Acute Heart Disease: Range of Predicted Mortality Rate/Percent	Metabolic & Electrolyte Disturbances: Number of Patients	Metabolic & Electrolyte Disturbances: Actual Mortality Rate/Percent	Metabolic & Electrolyte Disturbances: Range of Predicted Mortality Rate/Percent	Pulmonary Disease: Number of Patients	Pulmonary Disease: Actual Mortality Rate/Percent	Pulmonary Disease: Range of Predicted Mortality Rate/Percent
ADAIR CO MEM HOSP GREENFIELD IA 50849	IA-11 *	149	23	9-22	9	33	8-63	6	33	6-70	9	56	5-57	12	50	7-53	7	43	16-79	4	50	3-77	17	41	11-52
AKRON CITY HOSPITAL AKRON IA 51001	IA-12 *	13	15	4-45	1	100	2-98	1	100	0-97	.	.		.	.		.	.		.	.		4	0	3-77
ALLEN MEM HOSP WATERLOO IA 50703	IA-13	2222	9	8-14	149	15	13-30	71	21	18-40	44	20	10-36	108	23	16-33	91	38	30-52	23	17	10-47	142	17	13-28
ANAMOSA COMM HOSP ANAMOSA IA 52205	IA-14 *	213	17	9-21	7	71	10-71	8	25	7-64	5	40	3-71	15	13	8-50	11	55	16-69	5	0	3-71	24	29	8-42
AUDUBON CO MEM HOSP AUDUBON IA 50025	IA-15 *	113	15	9-23	4	25	2-74	5	0	8-77	4	25	2-75	6	0	3-64	5	0	12-83	3	33	2-82	19	21	7-44
BAUM HARMON MEM HOSP PRIMGHAR IA 51245	IA-16 *	164	18	11-24	10	20	7-58	7	43	11-73	12	17	4-49	12	17	8-55	3	67	6-86	4	25	4-78	21	19	9-44
BELMOND COMM HOSP BELMOND IA 50421	IA-17 *	89	17	9-25	8	50	10-69	3	67	3-83	4	25	2-74	5	40	4-71	7	43	11-73	.	.		16	13	7-47
BOONE CO HOSP BOONE IA 50036	IA-18 *	639	14	10-18	34	38	17-49	34	38	18-49	14	36	6-48	37	16	13-41	28	39	26-62	13	0	4-48	65	23	13-35
BROADLAWNS MED CTR DES MOINES IA 50314	IA-19 *	482	9	5-13	14	50	8-53	12	8	8-55	12	25	3-47	15	20	8-50	16	50	17-62	15	20	6-48	48	17	7-29
BUENA VISTA CO HOSP STORM LAKE IA 50588	IA-20	511	15	10-19	33	24	13-45	22	64	15-53	17	29	7-47	23	17	10-44	25	44	25-63	4	25	1-74	45	18	15-42
BURGESS MEM HOSP ONAWA IA 51040	IA-21	408	18	11-20	21	33	10-48	29	34	16-49	14	14	5-47	21	24	11-48	20	30	20-61	5	20	1-68	48	35	16-42
BURLINGTON MED CTR BURLINGTON IA 52601	IA-22	1804	13	9-16	143	27	17-35	59	29	17-41	34	18	8-36	69	26	14-34	97	44	30-51	22	14	6-41	195	20	14-28
CASS CO MEM HOSP ATLANTIC IA 50022	IA-23	595	13	10-18	31	45	13-46	31	16	15-47	16	13	9-50	46	30	13-38	15	60	23-70	8	25	4-59	55	15	12-35
CENTRAL COMM HOSP ELKADER IA 52043	IA-24 *	182	17	11-23	10	70	16-71	10	40	12-66	2	0	0-90	16	19	9-50	7	43	15-78	3	100	2-82	26	8	11-44
CHARTER COMM HOSP OF DES M DES MOINES IA 50310	IA-25	394	11	9-17	30	27	11-43	14	29	11-56	9	22	5-57	26	12	10-42	5	60	15-85	3	0	0-83	62	15	10-32
CLARKE CO PUBLIC HOSP OSCEOLA IA 50213	IA-26 *	113	13	9-24	5	60	5-73	4	25	5-78	4	25	2-75	10	20	6-56	9	44	17-74	2	0	0-93	18	22	8-46
COMM HOSP AND HLTH CTR SIOUX CENTER IA 51250	IA-27 *	133	11	8-21	12	33	11-60	5	20	6-74	4	50	3-76	3	0	2-81	5	60	12-83	3	0	1-81	10	20	10-62
COMM MEM HOSP HARTLEY IA 51346	IA-28	80	18	10-28	6	0	4-67	2	50	2-90	1	0	0-99	9	56	10-65	4	25	6-81	1	100	1-98	11	18	9-59
COMM MEM HOSP SUMNER IA 50674	IA-29 *	127	16	9-23	6	50	7-72	3	0	3-83	5	0	2-69	10	10	5-54	4	25	8-83	2	0	2-90	23	26	9-44
COMMUNITY MEM HOSP CLARION IA 50525	IA-30 *	169	14	9-22	3	67	7-88	1	100	1-97	9	11	1-52	12	33	8-56	4	50	9-84	6	17	3-66	28	14	12-45
COMMUNITY MEM HOSP MISSOURI VALLEY IA 51555	IA-31 *	266	14	9-19	11	27	6-55	15	33	13-58	10	20	4-53	7	29	4-63	5	40	10-81	13	38	6-52	39	26	12-39
COMMUNITY MEM HOSP POSTVILLE IA 52162	IA-32 *	91	25	10-27	3	33	3-83	9	44	12-68	4	75	3-76	7	71	6-66	1	100	2-98	1	100	1-97	13	23	7-52
COVENANT MEDICAL CENTER-SC WATERLOO IA 50702	IA-33 *	1686	12	9-16	140	29	19-38	50	30	19-45	35	17	8-35	70	37	17-38	60	38	28-54	32	19	6-35	116	17	13-30
CRAWFORD CO MEM HOSP DENISON IA 51442	IA-34 *	379	18	10-20	17	41	15-59	12	58	11-59	12	17	3-48	21	52	12-49	20	45	19-60	13	15	7-53	52	23	12-36
DALLAS CO HOSP PERRY IA 50220	IA-35 *	224	18	10-21	5	20	5-74	3	33	3-83	6	33	3-65	7	29	6-66	7	43	19-82	8	13	5-61	55	29	13-36
DAVENPORT OSTEO HOSP DAVENPORT IA 52806	IA-36 *	473	14	7-15	16	6	4-43	15	53	15-60	10	60	6-56	22	32	10-45	10	50	15-69	19	11	5-41	45	16	8-31

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
AOAIR CO MEM HOSP GREENFIELD IA 50849	1	0	0-99	1	0	1-97	1	0	0-99				16	0	0-35	4	75	1-73	2	0	0-100	14	0	0-38	4	0	0-99			
AKRON CITY HOSPITAL AKRON IA 51001	.	.	.	.	.	.	.	.	.				.	.	.	.	.	.	.	.	.	.	.	.						
ALLEN MEM HOSP WATERLOO IA 50703	15	7	5-50	12	25	14-66	52	12	4-22	.	.	.	226	6	3-11	106	4	1-12	11	0	0-96	260	4	3-9	235	3	0-5			
ANAMOSA COMM HOSP ANAMOSA IA 52205	3	67	8-90	.	.		3	0	0-87				23	9	1-27	2	0	0-95	.	.		17	6	1-32	9	11	0-58			
AUDUBON CO MEM HOSP AUDUBON IA 50025	.	.		1	100	3-99	11	9	3-48	.	.		6	0	0-65	4	0	0-83	1	0	0-100	10	20	0-49	3	0	0-100			
BAUM HARMON MEM HOSP PRIMGHAR IA 51245	6	0	7-74	5	40	10-81	1	0	0-99				20	5	1-29	3	0	0-84	1	0	0-100	10	0	0-52	8	13	0-66			
BELMOND COMM HOSP BELMOND IA 50421	1	100	1-97	.	.		.	.					10	0	0-53	.	.		.	.		7	0	0-63	6	0	0-98			
BOONE CO HOSP BOONE IA 50036	4	25	2-76	5	40	11-82	24	8	2-29				81	12	2-14	22	5	0-30	5	0	0-100	71	1	2-14	39	3	0-16			
BROADLAWNS MED CTR DES MOINES IA 50314	6	33	5-71				6	0	0-64	2	0	0-100	32	0	1-20	9	0	0-51	4	0	0-100	31	3	1-20	6	0	0-99			
BUENA VISTA CO HOSP STORM LAKE IA 50588	3	33	6-88	5	60	11-81	3	33	0-83	.	.		62	5	2-15	27	7	1-25	1	100	0-97	37	5	1-18	17	12	0-38			
BURGESS MEM HOSP ONAWA IA 51040	7	29	14-78	2	50	5-93	7	0	2-59	.	.		45	16	2-18	15	7	1-37	.	.		41	10	2-20	18	6	0-36			
BURLINGTON MED CTR BURLINGTON IA 52601	5	60	2-71	8	25	13-74	76	8	3-18	2	0	0-100	163	4	2-9	92	2	2-14	15	0	0-98	127	6	2-10	113	2	0-7			
CASS CO MEM HOSP ATLANTIC IA 50022	5	40	6-76	5	40	9-79	23	0	4-34	1	0	0-100	98	6	2-13	25	0	0-28	10	0	0-100	35	3	1-19	27	7	0-23			
CENTRAL COMM HOSP ELKADER IA 52043	3	33	2-83	1	0	2-98	2	0	0-96	.	.		21	10	1-29	1	0	0-100	.	.		13	0	0-40	3	0	0-100			
CHARTER COMM HOSP OF OES M OES MOINES IA 50310	3	0	6-87	3	0	4-85	18	11	2-34	3	0	0-100	33	9	1-22	16	0	1-35	2	0	0-100	29	7	1-22	18	0	0-66			
CLARKE CO PUBLIC HOSP OSCEOLA IA 50213	1	0	0-98				.	.	.				12	0	0-42	3	0	0-93	.	.		8	0	0-59	2	0	0-92			
COMM HOSP AND HLTH CTR SIOUX CENTER IA 51250	5	0	2-71	.			2	0	0-96		.		41	0	1-17	14	0	0-47				6	17	0-72	2	0	0-100			
COMM MEM HOSP HARTLEY IA 51346							2	0	1-89				10	20	1-46	1	0	0-99				8	0	0-57	1	0	0-100			
COMM MEM HOSP SUMNER IA 50674	1	100	0-97	5	20	10-81							15	7	0-38	5	40	0-76	2	0	0-100	12	8	0-41	2	0	0-92			
COMMUNITY MEM HOSP CLARION IA 50525	3	33	3-84	1	0	1-97	2	0	0-92				17	6	1-32	6	17	2-63	1	0	0-100	15	7	1-35	8	0	0-65			
COMMUNITY MEM HOSP MISSOURI VALLEY IA 51555				2	0	3-91	6	33	1-62				30	3	1-22	11	0	0-45	5	0	0-100	19	5	0-29	7	0	0-97			
COMMUNITY MEM HOSP POSTVILLE IA 52162	3	0	4-85	1	0	3-99	3	33	1-81	1	0	0-100	4	0	0-77	1	0	0-100	2	0	0-100	8	0	0-57	6	0	0-90			
COVENANT MEDICAL CENTER-SC WATERLOO IA 50702	11	9	8-61	13	15	15-65	34	12	3-27	3	0	0-100	191	6	3-11	87	5	1-13	17	6	0-95	111	12	3-12	170	1	1-7			
CRAWFORD CO MEM HOSP DENISON IA 51442	2	100	3-92	7	71	13-77	3	0	0-82	.	.		64	14	3-17	25	0	1-26	2	0	0-100	24	0	1-25	17	6	0-61			
DALLAS CO HOSP PERRY IA 50220	2	50	1-90	4	50	9-84	4	25	1-74	1	0	0-100	22	9	1-27	8	0	1-54	1	0	0-100	19	0	0-30	13	15	0-55			
DAVENPORT OSTEO HOSP DAVENPORT IA 52806	3	33	6-88	9	22	14-72	8	0	0-56	.			50	6	1-16	25	8	1-26	5	0	0-100	30	3	1-21	27	4	0-42			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
DAVIS CO HOSP BLOOMFIELD IA 52537	IA-37 *	431	11	9-17	25	28	10-44	16	31	13-56	22	14	5-38	16	38	10-52	28	39	23-59	4	25	5-79	31	10	8-37						
DECATUR CO HOSP LEON IA 50144	IA-38	353	19	10-19	8	25	6-63	20	60	14-52	6	17	2-63	11	73	6-54	21	62	23-64	8	13	3-58	55	29	11-34						
DELAWARE CO MEM HOSP MANCHESTER IA 52057	IA-39 *	310	12	10-19	28	21	15-50	13	46	13-60	8	25	4-59	21	19	9-45	12	42	17-68	7	14	7-68	23	9	8-42						
DES MOINES GEN HOSP DES MOINES IA 50307	IA-40	1497	11	9-16	102	19	15-34	52	15	17-43	25	4	7-40	56	32	14-37	60	38	27-53	47	13	7-32	117	17	13-30						
DEWITT COMM HOSP DE WITT IA 52742	IA-41	183	19	10-22	9	33	7-61	5	60	7-76	4	25	5-79	11	36	10-61	8	38	17-77	3	33	2-82	27	30	11-43						
DICKINSON CO MEM HOSP SPIRIT LAKE IA 51360	IA-42 *	373	13	7-16	40	23	11-39	13	46	14-62	10	20	2-49	7	0	4-63	15	20	18-65	9	11	2-54	33	18	10-38						
EDMUNDSON JENNIE MEM HOSP COUNCIL BLUFFS IA 51501	IA-43 *	1435	11	9-16	100	17	17-37	66	20	17-39	23	17	5-38	48	29	13-37	48	52	29-57	26	19	7-40	140	18	15-30						
ELDORA COMM HOSP ELDORA IA 50627	IA-44 *	100	16	8-23	3	33	2-81	5	20	5-73	2	0	0-90	5	40	3-70	4	25	8-83	8	25	2-57	16	25	9-51						
ELLSWORTH MUNICIPAL HOSP IOWA FALLS IA 50126	IA-45 *	303	20	11-21	19	58	13-54	17	41	15-57	11	27	4-50	19	53	10-48	18	39	20-64	15	27	8-52	34	29	11-40						
FINLEY HOSP DUBUQUE IA 52001	IA-46	1292	11	9-16	117	24	17-37	45	22	17-44	22	27	11-47	52	23	14-37	35	26	24-56	29	21	8-40	71	21	15-36						
FLOYD CO MEM HOSP CHARLES CITY IA 50616	IA-47	481	15	10-19	42	14	12-40	18	44	13-54	13	23	6-51	34	18	11-40	21	43	24-65	11	45	12-65	51	27	13-37						
FLOYD VALLEY HOSP LE MARS IA 51031	IA-48 *	349	10	9-18	28	25	10-43	11	18	10-61	12	8	4-49	18	22	12-53	11	55	17-69	8	0	2-56	46	9	9-33						
FOREST CITY COMM HOSP FOREST CITY IA 50436	IA-49 *	102	10	7-22	2	50	2-90	2	50	1-89	3	33	1-81	6	0	5-68	3	0	9-90	6	33	3-65	14	36	8-52						
FRANKLIN GEN HOSP HAMPTON IA 50441	IA-50 *	238	17	12-23	17	18	12-54	12	33	14-64	12	17	3-48	19	21	9-47	18	39	19-62	9	22	4-56	30	20	10-41						
FT MADISON COMM HOSP FORT MADISON IA 52627	IA-51 *	506	15	8-16	28	36	12-45	13	46	11-58	10	60	3-51	26	35	9-40	19	47	18-60	25	36	10-46	56	14	9-30						
GAY VIRGINIA HOSP VINTON IA 52349	IA-52 *	250	13	9-20	8	38	3-58	22	14	14-52	10	30	4-53	17	29	9-49	13	31	18-68	8	25	2-57	18	17	11-52						
GRAPE COMMUNITY HOSP HAMBURG IA 51640	IA-53 *	253	15	10-20	13	23	11-59	12	17	11-60	8	25	2-55	21	38	10-47	16	44	17-62	1	0	0-99	29	17	10-41						
GREATER COMMUNITY HOSP CRESTON IA 50801	IA-54 *	516	12	8-16	39	23	12-41	18	28	11-51	9	11	2-53	26	31	10-43	14	71	20-68	7	0	1-59	51	20	10-33						
GREELEY MARY MEO CTR AMES IA 50010	IA-55	1609	10	8-15	185	16	18-35	49	22	18-44	35	9	9-37	52	31	14-38	27	56	22-59	18	28	10-51	99	17	13-31						
GREENE CO MEO CTR JEFFERSON IA 50129	IA-56 *	409	15	10-19	26	23	18-55	31	23	15-46	13	8	8-53	15	20	6-46	22	50	23-63	3	33	1-82	28	29	8-39						
GRINNELL GEN HOSP GRINNELL IA 50112	IA-57 *	636	10	8-16	30	10	8-38	16	44	13-56	12	8	5-51	32	31	13-42	14	14	20-68	9	33	4-56	72	14	12-32						
GRUNDY CO MEM HOSP GRUNDY CENTER IA 50638	IA-58 *	61	23	10-31	.	.	.	1	0	1-97	4	25	2-75	11	36	7-56	2	100	3-91	.	.	.	11	18	10-60						
GUTHRIE CO HOSP GUTHRIE CENTER IA 50115	IA-59 *	212	15	10-21	9	44	6-59	8	50	11-70	5	20	5-74	9	22	9-64	17	47	21-66	3	0	0-84	26	19	7-38						
GUTTENBERG MUNICIPAL HOSP GUTTENBERG IA 52052	IA-60 *	182	13	9-20	12	50	14-65	8	13	8-66	5	0	1-68	8	0	8-65	6	33	13-79	6	0	1-64	25	28	9-42						
HAMILTON CO PUBLIC HOSP WEBSTER CITY IA 50595	IA-61	437	13	9-17	21	71	19-60	9	22	9-64	12	25	4-49	26	19	10-42	15	27	19-66	15	47	8-52	44	11	12-38						
HANCOCK CO MEM HOSP BRITT IA 50423	IA-62 *	136	22	10-23	1	100	3-99	3	33	4-84	6	67	2-64	9	22	7-61	10	50	15-70	4	50	1-74	13	23	8-53						

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
DAVIS CO HOSP BLOOMFIELD IA 52537	3	33	6-88	7	14	7-69	15	7	0-37				56	2	1-15	15	7	1-36	1	0	0-100	37	0	1-19	21	0	0-30
DECATUR CO HOSP LEON IA 50144	5	20	5-75	5	20	9-80	4	0	0-78	.	.		44	5	1-17	10	0	0-49	2	50	0-100	36	3	1-19	8	0	0-86
DELAWARE CO MEM HOSP MANCHESTER IA 52057	3	0	0-90	3	33	3-84	2	50	0-80	.	.		29	3	1-22	9	11	1-50	7	0	0-100	33	6	1-21	10	10	0-64
DES MOINES GEN HOSP DES MOINES IA 50307	15	20	10-58	13	31	13-62	44	5	3-22	7	0	0-100	168	5	3-10	51	6	2-18	16	0	0-99	112	6	2-11	89	6	0-8
DEWITT COMM HOSP DE WITT IA 52742	.	.		3	67	5-85	1	0	0-100		.		26	4	1-25	5	20	0-83	1	0	0-100	15	7	1-35	3	0	0-98
DICKINSON CO MEM HOSP SPIRIT LAKE IA 51360	2	50	1-90	.	.		8	13	0-55		.		46	9	1-16	23	4	1-27	5	0	0-100	35	11	1-19	32	0	0-30
EDMUNDSON JENNIE MEM HOSP COUNCIL BLUFFS IA 51501	11	18	5-56	8	25	9-68	47	4	5-25	10	0	0-93	151	7	3-11	59	2	1-16	14	0	0-83	71	3	2-14	169	1	0-6
ELDORA COMM HOSP ELDORA IA 50627	1	100	0-97				2	50	0-90				20	5	1-29	2	0	0-99	1	0	0-100	7	0	0-60	1	0	0-100
ELLSWORTH MUNICIPAL HOSP IOWA FALLS IA 50126	3	33	3-83	4	25	9-84	1	0	0-99		.		34	3	0-19	2	0	0-92	7	0	0-100	29	7	1-22	14	0	0-38
FINLEY HOSP DUBUQUE IA 52001	22	14	13-55	15	47	25-73	51	12	3-21	3	0	0-100	109	6	2-12	65	2	1-15	13	0	0-85	85	2	2-13	202	2	1-6
FLOYD CO MEM HOSP CHARLES CITY IA 50616	4	50	5-80	1	0	0-97	17	24	1-34		.		49	4	2-18	16	6	0-44				47	4	1-16	35	6	0-19
FLOYD VALLEY HOSP LE MARS IA 51031	1	0	0-97	8	38	10-69	3	0	0-88		.		57	2	1-15	17	6	1-33	4	0	0-100	22	0	1-26	10	0	0-73
FOREST CITY COMM HOSP FOREST CITY IA 50436	2	0	3-91	.	.		.				.		13	0	0-45	.						7	0	0-74	4	0	0-89
FRANKLIN GEN HOSP HAMPTON IA 50441		.		2	0	2-90	3	33	0-82				29	10	2-24	4	0	0-96	1	0	0-100	18	11	1-31	7	0	0-75
FT MADISON COMM HOSP FORT MADISON IA 52627	8	13	4-63	3	100	10-92	9	0	0-51	2	0	0-100	63	6	1-14	28	4	1-24	7	0	0-100	38	3	1-17	25	0	0-25
GAY VIRGINIA HOSP VINTON IA 52349	.	.		2	100	6-94	3	33	1-81				31	0	1-21	4	0	0-75	2	0	0-100	31	0	1-21	12	0	0-67
GRAPE COMMUNITY HOSP HAMBURG IA 51640	3	33	6-88	1	100	1-97	4	0	0-75	.	.		27	4	1-23	19	0	1-31	1	0	0-100	19	5	0-29	14	0	0-71
GREATER COMMUNITY HOSP CRESTON IA 50801	3	0	3-83	4	50	8-83	6	33	0-64		.		68	6	2-14	19	16	1-31	8	0	0-100	36	0	1-19	22	5	0-31
GREELEY MARY MEO CTR AMES IA 50010	6	33	8-74	28	29	21-58	41	15	2-21	16	0	0-95	180	2	3-10	94	0	1-13	28	0	0-88	63	5	2-16	183	1	0-5
GREENE CO MEO CTR JEFFERSON IA 50129	4	75	5-80	5	20	7-77	20	25	3-35	.			78	6	2-14	16	0	0-36	5	0	0-100	26	4	1-24	16	0	0-48
GRINNELL GEN HOSP GRINNELL IA 50112	4	25	3-77	3	67	4-84	10	20	2-48	1	0	0-100	65	5	2-16	22	5	0-29	5	0	0-100	34	6	1-21	47	0	0-15
GRUNOY CO MEM HOSP GRUNOY CENTER IA 50638		.									.		8	13	0-54	4	0	0-78	1	0	0-100	4	50	1-73	1	0	0-100
GUTHRIE CO HOSP GUTHRIE CENTER IA 50115	7	29	5-67	2	0	2-90	16	0	2-37		.		29	3	0-22	3	0	0-97	5	0	0-100	12	8	1-41	10	0	0-69
GUTTENBERG MUNICIPAL HOSP GUTTENBERG IA 52052		.		2	0	6-95	1	0	0-98				19	11	1-30	9	11	0-58	6	0	0-75	13	0	0-39	15	7	0-45
HAMILTON CO PUBLIC HOSP WEBSTER CITY IA 50595	2	0	0-91	3	33	6-87	1	0	0-100				57	5	2-15	18	11	1-32	.			54	2	1-14	29	3	0-26
HANCOCK CO MEM HOSP BRITT IA 50423	1	100	0-97		.		2	0	0-94				19	5	1-31	3	0	1-81	.	.		10	10	1-46	3	33	0-96

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HAWAREN COMMUNITY HOSP HAWAREN IA 51023	IA-63 *	109	19	9-24	3	100	7-88	4	50	4-77	5	60	6-75	3	0	3-83	6	33	16-83	6	50	4-67	14	29	8-52
HEGG MEMORIAL HOSP ROCK VALLEY IA 51247	IA-64 *	109	20	11-27	7	29	9-71	2	50	1-89	.	.		7	43	5-64	8	38	13-73	4	0	4-77	23	35	11-47
HENRY CO HEALTH CTR MOUNT PLEASANT IA 52641	IA-65	296	16	10-20	14	21	11-57	17	24	11-53	16	13	6-46	10	40	6-57	14	64	21-69	8	13	1-56	24	17	10-45
HOLY FAMILY HOSP ESTHERVILLE IA 51334	IA-66	354	11	8-17	20	10	8-45	9	33	7-60	4	0	0-78	12	25	7-53	24	46	27-65	6	17	2-64	36	22	9-37
HORN MEM HOSP IDA GROVE IA 51445	IA-67 *	227	19	11-22	10	50	16-71	15	33	11-54	5	0	1-68	15	53	7-49	10	60	15-70	2	50	3-91	37	30	13-41
HOWARD CO HOSP CRESCO IA 52136	IA-68 *	230	13	10-20	9	33	6-60	22	41	15-53	4	0	1-74	12	8	7-54	8	38	16-76	7	29	2-60	26	15	9-41
HUMBOLOT CO MEM HOSP HUMBOLOT IA 50548	IA-69 *	172	13	8-20	10	40	9-62	7	14	7-67	9	33	3-54	8	38	5-60	3	0	7-88	8	13	2-57	31	13	9-38
IOWA LUTHERAN HOSP DES MOINES IA 50316	IA-70 *	1536	11	9-15	98	16	15-35	37	14	16-46	30	17	10-42	55	31	15-38	52	48	27-54	32	19	10-42	118	19	14-31
IOWA METHODIST MED CTR DES MOINES IA 50308	IA-71	4083	10	8-15	389	20	17-31	83	23	19-39	91	16	12-32	92	17	16-35	127	43	29-48	54	15	11-36	253	21	15-28
JACKSON CO PUBLIC HOSP MAQUOKETA IA 52060	IA-72 *	493	14	10-18	25	24	11-46	27	33	17-51	14	36	9-53	23	17	11-46	17	76	21-66	19	26	7-44	60	18	12-33
JEFFERSON CO HOSP FAIRFIELD IA 52556	IA-73 *	369	17	12-21	25	32	19-56	29	48	19-52	4	50	8-82	21	48	14-53	13	38	20-69	9	22	3-55	35	23	10-38
KEOKUK AREA HOSP KEOKUK IA 52632	IA-74 *	854	14	9-17	57	28	13-37	33	39	15-45	32	16	6-35	33	27	11-40	37	49	27-58	15	7	3-42	114	25	15-32
KEOKUK CO HOSP SIGOURNEY IA 52591	IA-75 *	132	17	11-25	3	33	7-88	2	50	4-92	1	0	0-98	8	75	9-67	11	27	17-70	5	20	3-70	19	37	10-49
KNOXVILLE AREA COMM HOSP KNOXVILLE IA 50138	IA-76 *	414	16	10-19	19	26	11-51	15	27	12-57	17	24	4-42	24	29	11-45	28	43	23-58	20	35	13-53	47	17	11-36
KOSSUTH CO HOSP ALGONA IA 50511	IA-77 *	227	14	10-21	8	50	9-67	7	14	10-71	4	0	4-77	17	35	8-47	19	37	20-62	5	0	3-71	22	18	11-47
LAMB JANE MEM HOSP CLINTON IA 52732	IA-78	713	13	8-16	50	28	15-41	30	33	13-45	20	25	4-39	34	24	13-42	28	50	24-60	12	8	3-47	77	21	9-28
LORING HOSPITAL SAC CITY IA 50583	IA-79 *	181	14	8-20	14	43	12-59	6	33	9-74	4	25	2-75	5	0	3-70	12	25	16-67	1	0	0-98	20	25	8-44
LUCAS CO MEM HOSP CHARITON IA 50049	IA-80	254	16	10-21	5	40	5-73	7	29	9-71	5	40	3-70	22	27	11-47	4	50	8-83	4	75	4-78	46	24	16-42
MADISON CO MEM HOSP WINTERSET IA 50273	IA-81 *	194	15	8-20	10	30	7-59	8	50	9-67	3	0	1-82	12	25	10-58	3	67	7-88	8	25	4-60	30	27	9-39
MAHASKA CO HOSP OSKALOOSA IA 52577	IA-82 *	470	15	9-18	28	29	9-41	23	43	16-53	13	23	4-47	21	33	9-44	24	25	23-61	25	20	8-43	36	22	9-36
MANNING GEN HOSP MANNING IA 51455	IA-83 *	142	13	10-24	12	25	11-60	4	0	3-77	4	25	2-74	5	0	4-72	9	33	20-78		.		24	25	12-47
MARENCO MEM HOSP MARENGO IA 52301	IA-84 *	100	15	7-22	2	0	4-92	1	100	1-97	1	0	0-99	10	10	6-56	4	50	9-84	9	22	6-59	12	33	4-49
MARIAN HEALTH CENTER SIOUX CITY IA 51102	IA-85	2834	12	9-15	217	27	19-36	65	40	19-42	59	24	8-30	123	28	17-33	121	46	30-49	26	27	9-42	183	21	16-31
MARSHALLTOWN AREA COMM HOS MARSHALLTOWN IA 50158	IA-86	1618	10	8-14	88	25	13-34	48	27	17-43	48	19	9-33	77	19	13-32	48	46	26-54	50	10	8-33	150	20	14-29
MCDONALD JOHN HOSP MONTICELLO IA 52310	IA-87 *	131	6	7-19	3	0	0-83	4	0	5-78	5	0	3-70	11	9	6-54	2	50	3-91	5	0	1-68	23	13	7-41
MERCY HEALTH CTR DUBUQUE IA 52001	IA-88	2468	10	7-14	155	12	12-29	68	28	19-41	61	20	12-35	106	23	15-32	89	44	26-47	62	16	9-32	142	24	14-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HAWARDEN COMMUNITY HOSP HAWARDEN IA 51023	2	0	2-91							.	.	.	9	11	0-54	3	0	0-86	2	0	0-100	14	0	0-37	1	0	0-100
HEGG MEMORIAL HOSP ROCK VALLEY IA 51247	4	50	7-82	1	0	0-97	.	.		.	.	.	16	0	0-38	10	0	0-58	.	.		2	0	0-94	1	100	0-97
HENRY CO HEALTH CTR MOUNT PLEASANT IA 52641	2	0	0-91	2	100	7-95	1	0	0-99	.	.	.	39	13	2-20	5	20	0-71	2	0	0-100	20	0	1-28	11	9	0-50
HOLY FAMILY HOSP ESTHERVILLE IA 51334	2	0	1-90				16	6	1-35				42	5	1-18	29	3	0-24	4	0	0-100	22	5	2-29	44	2	0-16
HORN MEM HOSP IDA GROVE IA 51445	3	33	2-83	3	33	4-85	12	0	2-43	.			27	4	1-24	10	10	1-47	1	0	0-100	17	12	1-32	12	0	0-45
HOWARD CO HOSP CRESCO IA 52136	4	0	3-77	5	20	8-78	3	0	0-82	.	.		25	4	1-25	12	8	0-43	3	0	0-100	21	5	1-27	5	0	0-98
HUMBOLDT CO MEM HOSP HUMBOLDT IA 50548	1	100	1-97	3	67	4-85	.	.					22	5	1-28	9	0	0-59	6	0	0-100	5	20	0-69	6	0	0-99
IOWA LUTHERAN HOSP DES MOINES IA 50316	15	20	6-52	9	44	15-73	59	7	4-20	30	0	0-42	137	4	3-12	127	3	2-12	20	0	0-94	75	4	2-14	111	1	1-8
IOWA METHODIST MED CTR DES MOINES IA 50308	34	18	9-44	29	45	25-62	154	10	4-15	16	0	0-99	344	6	4-10	171	1	1-11	34	0	0-33	368	9	3-9	525	1	0-3
JACKSON CO PUBLIC HOSP MAQUOKETA IA 52060	4	25	2-77	7	29	8-70	8	13	0-54				65	6	1-14	8	38	0-56	2	0	0-100	54	2	2-16	20	0	0-37
JEFFERSON CO HOSP FAIRFIELD IA 52556	3	33	4-85	2	0	4-93	21	10	2-32	.			45	7	3-20	6	0	0-75	5	0	0-84	44	2	1-17	25	0	0-25
KEOKUK AREA HOSP KEOKUK IA 52632	3	33	1-82	5	60	9-80	30	10	1-24	2	0	0-100	89	9	2-12	32	0	1-22	11	0	0-95	64	3	2-14	38	5	0-17
KEOKUK CO HOSP SIGOURNEY IA 52591				1	0	1-97	2	0	0-91	.			6	0	0-65	2	0	0-94	.	.		16	6	0-34	6	0	0-70
KNOXVILLE AREA COMM HOSP KNOXVILLE IA 50138	2	0	0-95				3	33	1-81	.			47	6	1-16	5	20	0-72	4	0	0-100	26	4	1-23	24	8	0-25
KOSSUTH CO HOSP ALGONA IA 50511	2	50	3-92	2	50	3-91	.	.		.	.		47	9	2-17	1	0	0-100	1	0	0-100	17	0	1-32	9	0	0-82
LAMB JANE MEM HOSP CLINTON IA 52732	3	67	1-82	8	50	12-72	19	11	2-33	6	0	0-100	75	4	2-13	33	9	1-22	10	0	0-100	51	8	1-16	43	2	0-16
LORING HOSPITAL SAC CITY IA 50583	1	0	1-97	1	0	1-97	15	13	1-37				17	6	1-32	7	0	0-69	4	0	0-100	5	0	0-75	14	0	0-49
LUCAS CO MEM HOSP CHARITON IA 50049	2	100	7-95	2	0	2-90	8	13	1-54				35	9	2-22	15	13	1-36	2	0	0-100	23	9	1-26	14	0	0-39
MADISON CO MEM HOSP WINTERSET IA 50273	1	0	0-97	1	100	1-97	11	0	2-46				28	7	1-23	10	20	0-51	1	0	0-100	18	0	1-31	1	0	0-100
MAHASKA CO HOSP OSKALOOSA IA 52577	2	0	1-90	3	33	6-88	17	24	3-38				58	2	1-15	31	0	1-24	1	0	0-100	40	8	2-19	18	17	0-35
MANNING GEN HOSP MANNING IA 51455	1	100	2-98				7	14	1-58				17	18	1-32	3	0	0-86	2	0	0-98	5	0	0-69	8	0	0-69
MARENGO MEM HOSP MARENGO IA 52301							4	0	1-73				9	0	0-57							10	0	0-53	7	14	0-89
MARIAN HEALTH CENTER SIOUX CITY IA 51102	27	15	12-51	30	40	24-61	74	5	3-18	31	0	0-35	263	6	3-10	136	8	1-12	19	0	0-91	346	5	3-8	226	0	1-5
MARSHALLTOWN AREA COMM HOS MARSHALLTOWN IA 50158	11	55	11-65	11	27	16-69	49	2	3-20	148	0	0-6	177	3	2-9	49	2	1-17	18	6	0-39	93	3	2-11	98	2	0-8
MCDONALD JOHN HOSP MONTICELLO IA 52310	3	0	1-82							.			12	0	0-44	3	0	0-83				8	0	0-55	5	0	0-100
MERCY HEALTH CTR DUBUQUE IA 52001	17	12	7-51	28	29	21-58	105	8	4-17	17	0	0-91	208	6	2-9	86	7	1-13	30	3	0-90	216	6	2-8	208	1	0-5

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																													
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease											
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent								
MERCY HOSP CEDAR RAPIDS IA 52403	IA-89	2519	11	9-15	212	17	17-33	82	28	19-39	63	6	9-31	107	16	16-33	71	38	27-50	53	25	9-34	221	23	15-28								
MERCY HOSP COUNCIL BLUFFS IA 51502	IA-90 *	1428	11	8-15	78	21	15-38	49	18	16-41	32	13	7-36	68	21	12-33	37	49	25-57	35	14	11-41	132	23	14-30								
MERCY HOSP IOWA CITY IA 52240	IA-91	2025	9	8-14	210	16	14-30	95	29	20-40	41	17	9-36	96	21	15-33	65	29	26-51	19	11	8-46	119	18	14-31								
MERCY HOSP OF FRANCISCAN S OELWEIN IA 50662	IA-92 *	232	15	9-19	9	44	8-63	9	78	12-68	3	67	1-81	13	23	7-52	9	67	16-73	9	0	3-54	23	13	10-45								
MERCY HOSPITAL CORNING IA 50841	IA-93	163	10	9-21	8	13	5-62	8	25	10-68	4	50	3-76	5	20	3-69	7	14	11-73	5	20	1-69	18	22	12-53								
MERCY HOSPITAL DAVENPORT IA 52804	IA-94 *	1996	13	7-14	142	30	17-35	59	39	17-40	39	21	6-32	72	32	13-32	48	38	24-52	48	15	5-30	154	26	11-26								
MERCY HOSPITAL MED CTR DES MOINES IA 50314	IA-95	4811	12	9-15	287	18	16-31	145	30	20-36	93	20	11-30	224	27	17-29	263	33	31-45	103	17	9-29	364	21	15-27								
MERRILL-PIONEER COMM HOSP ROCK RAPIDS IA 51246	IA-96 *	191	20	14-27	14	57	17-65	19	42	16-57	7	14	4-63	14	29	14-61	7	29	12-75	1	100	0-97	30	20	13-44								
MITCHELL CO MEMORIAL HOSP OSAGE IA 50461	IA-97 *	357	10	8-17	18	17	8-48	9	33	10-66	10	0	1-49	24	13	9-41	15	40	19-66	2	0	0-91	23	26	8-42								
MONROE CO HOSP ALBIA IA 52531	IA-98 *	236	15	8-19	10	60	7-58	4	25	4-78	4	0	1-74	10	20	6-57	3	67	9-91	7	0	3-61	32	22	11-41								
MONTGOMERY CO MEM HOSP RED OAK IA 51566	IA-99 *	668	10	10-18	20	35	9-46	35	26	17-47	10	10	4-54	32	13	13-43	24	38	26-64	9	22	3-54	82	16	15-35								
MUNICIPAL HOSP CLARINDA IA 51632	IA-100	301	15	9-19	16	56	13-57	10	30	11-65	11	18	4-50	19	37	8-45	13	54	18-67	8	13	3-57	29	17	10-41								
MUSCATINE GENERAL HOSP MUSCATINE IA 52761	IA-101*	648	13	9-17	38	21	13-43	27	30	15-48	15	20	2-40	28	11	11-42	33	52	26-59	9	22	5-58	67	24	12-33								
NORTH IOWA MED CENTER MASON CITY IA 50401	IA-102	1013	7	8-15	86	12	13-34	23	35	17-54	20	15	7-43	45	24	14-39	31	39	25-59	19	5	5-42	43	16	13-40								
NORTHWEST IOWA HEALTH CENT SHELDON IA 51201	IA-103*	160	16	11-24	10	10	7-58	10	30	11-65	7	29	2-59	15	40	11-54	6	67	12-79	4	25	5-79	21	14	9-44								
ORANGE CITY MUN HOSP ORANGE CITY IA 51041	IA-104*	206	12	9-21	12	42	10-59	14	43	13-59	7	29	5-65	15	27	8-49	5	40	12-82	5	0	2-69	19	26	13-53								
OSCEOLA COMM HOSP SIBLEY IA 51249	IA-105	194	11	10-21	16	31	13-57	11	27	10-61	1	0	0-99	12	8	10-58	4	25	8-83	4	0	1-75	25	20	9-42								
OTTUMWA REGIONAL HTH CTR OTTUMWA IA 52501	IA-106*	1273	13	9-16	68	15	13-35	59	29	19-43	13	46	9-55	63	27	14-36	58	38	28-54	20	35	10-48	101	22	13-31								
PALMER MEM HOSP WEST UNION IA 52175	IA-107	233	18	10-20	4	75	10-86	10	60	9-61	8	25	8-65	15	47	9-52	9	67	19-77	6	17	2-65	10	30	5-55								
PALO ALTO CO HOSP EMMETSBURG IA 50536	IA-108*	316	15	11-21	31	13	11-42	16	19	14-58	8	38	4-60	14	29	7-50	28	46	26-62	7	0	2-60	40	25	11-38								
PELLA COMM HOSP PELLA IA 50219	IA-109*	215	15	10-21	16	25	7-47	9	67	10-65	12	33	4-48	8	25	10-68	8	25	14-73				35	20	8-36								
PEOPLES MEMORIAL HOSP INDEPENDENCE IA 50644	IA-110*	242	21	10-21	11	82	13-66	17	35	16-59	11	18	4-52	24	17	10-44	7	71	19-82	5	0	1-68	28	21	8-39								
POCAHONTAS COMM HOSP POCAHONTAS IA 50574	IA-111*	191	23	14-26	16	25	10-53	8	38	9-67	6	17	2-63	29	24	13-45	10	60	18-73	3	0	0-87	34	47	17-49								
RINGGOLD CO HOSP MOUNT AYR IA 50854	IA-112*	169	18	10-23	11	55	10-62	9	22	8-62	3	0	1-81	7	29	5-63	8	0	15-75	4	0	3-76	34	26	11-40								
SARTORI MEM HOSP CEDAR FALLS IA 50613	IA-113*	625	12	9-16	39	13	9-36	30	50	16-49	21	24	7-43	24	17	11-45	24	29	24-62	10	30	3-51	47	23	12-36								
SHELBY CO MYRTUE MEM HOSP HARLAN IA 51537	IA-114*	486	13	10-19	18	11	8-48	21	33	15-54	12	17	5-50	29	28	12-43	16	38	23-69	10	0	7-58	91	23	15-34								

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MERCY HOSP CEDAR RAPIDS IA 52403	32	41	14-51	23	43	19-59	84	8	4-18	26	0	0-65	264	5	3-9	109	2	2-13	20	0	0-67	176	12	2-9	221	1	1-5
MERCY HOSP COUNCIL BLUFFS IA 51502	9	33	8-65	11	27	15-69	39	8	3-23	32	0	0-51	158	6	3-11	60	7	2-18	10	0	0-99	88	6	2-12	98	2	1-9
MERCY HOSP IOWA CITY IA 52240	6	33	5-71	9	44	10-67	91	7	4-17	34	0	0-44	238	4	3-9	86	6	1-13	29	0	0-78	118	5	2-11	223	1	0-5
MERCY HOSP OF FRANCISCAN S OELWEIN IA 50662	1	0	0-99	5	0	9-79							27	4	0-23	10	0	0-58	1	0	0-100	18	11	1-31	12	8	0-49
MERCY HOSPITAL CORNING IA 50841				1	0	1-97	15	7	1-37				24	0	1-26	3	33	0-84				5	40	1-68	11	0	0-61
MERCY HOSPITAL DAVENPORT IA 52804	12	25	11-63	17	41	15-60	63	17	3-19	27	0	0-81	188	7	2-10	58	5	1-16	6	0	0-100	109	7	2-11	214	0	0-5
MERCY HOSPITAL MED CTR DES MOINES IA 50314	33	30	11-47	32	34	18-53	115	9	4-16	77	0	0-13	407	5	3-9	219	5	2-11	34	0	0-45	790	5	3-7	310	2	1-4
MERRILL-PIONEER COMM HOSP ROCK RAPIDS IA 51246	2	50	2-90	3	33	8-89	6	0	2-63				15	0	1-36	7	0	0-60	1	0	0-100	10	0	0-48	8	0	0-65
MITCHELL CO MEMORIAL HOSP OSAGE IA 50461	2	50	3-91	3	0	6-87	7	0	1-57	1	0	0-100	39	3	2-20	9	0	0-54	4	0	0-100	43	5	1-17	23	0	1-25
MONROE CO HOSP ALBIA IA 52531	7	43	9-73	.	.		3	0	1-81	.	.		32	0	1-21	4	0	0-76	3	0	0-100	12	17	0-42	9	0	0-55
MONTGOMERY CO MEM HOSP RED OAK IA 51566	11	9	7-60	24	21	18-57	18	6	1-33				85	4	3-14	24	8	2-28	3	0	0-100	80	1	2-13	49	2	0-14
MUNICIPAL HOSP CLARINDA IA 51632	3	67	6-87				17	6	2-36				53	4	1-16	2	0	0-100	3	0	0-99	18	11	1-31	12	0	0-53
MUSCATINE GENERAL HOSP MUSCATINE IA 52761	4	0	3-78	10	70	14-70	25	12	2-28	3	0	0-100	68	6	1-13	23	4	0-28	8	0	0-100	59	7	1-14	38	5	0-17
NORTH IOWA MED CENTER MASON CITY IA 50401	4	50	8-85	11	18	15-68	28	11	3-29	2	0	0-100	144	2	2-10	89	0	1-13	15	0	0-96	65	2	2-14	95	1	0-8
NORTHWEST IOWA HEALTH CENT SHELDON IA 51201	1	100	1-98				7	0	0-61				25	4	1-24	6	0	4-67	2	0	0-100	9	0	0-51	7	0	0-63
ORANGE CITY MUN HOSP ORANGE CITY IA 51041				2	0	3-91	2	0	0-90	.	.		35	0	1-21	13	0	0-42	3	0	0-100	10	10	1-46	6	0	0-97
OSCEOLA COMM HOSP SIBLEY IA 51249	3	33	2-83	4	0	5-80	5	60	1-67	.			28	0	1-22	4	0	0-76	4	0	0-100	14	0	0-37	5	0	0-94
OTTUMWA REGIONAL HTH CTR OTTUMWA IA 52501	3	33	2-83	13	38	14-63	24	13	2-29	6	0	0-99	139	6	2-11	74	7	2-16	13	0	0-100	88	6	3-14	119	2	0-7
PALMER MEM HOSP WEST UNION IA 52175	1	0	1-97	2	0	9-97	2	0	0-91				17	0	1-32	8	0	0-75	1	0	0-100	10	10	0-49	4	25	0-93
PALO ALTO CO HOSP EMMETSBURG IA 50536	4	25	1-76	2	50	6-94	4	25	0-78				37	3	1-19	12	8	0-46	4	0	0-100	29	0	1-21	12	0	0-52
PELLA COMM HOSP PELLA IA 50219	6	0	10-77	6	0	13-80	19	21	2-32				24	4	1-27	3	0	0-91	3	0	0-100	12	8	1-41	5	0	0-99
PEOPLES MEMORIAL HOSP INDEPENDENCE IA 50644	4	75	6-82	1	100	2-98	3	33	0-84				17	6	0-33	19	26	3-34	1	0	0-100	16	13	1-34	5	0	0-99
POCAHONTAS COMM HOSP POCAHONTAS IA 50574	4	25	4-79	2	50	2-90	4	0	0-79				31	3	1-22	9	11	2-51	1	0	0-100	8	0	0-57	6	0	0-95
RINGGOLD CO HOSP MOUNT AYR IA 50854	3	33	8-90				4	0	3-76				22	9	1-28	8	0	0-65				18	6	1-31	7	0	0-74
SARTORI MEM HOSP CEDAR FALLS IA 50613	1	0	0-99	7	29	8-70	26	4	2-28				78	4	2-13	33	3	1-22	12	0	0-99	42	2	2-19	64	2	0-11
SHELBY CO MYRTUE MEM HOSP HARLAN IA 51537	6	50	12-80	3	33	10-91	10	10	1-47				37	11	1-19	16	0	0-36	5	0	0-100	38	3	1-18	15	0	0-55

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																											
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease										
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent							
SHENANDOAH MEM HOSP SHENANDOAH IA 51601	IA-115*	347	14	10-19	23	22	8-42	11	18	12-64	10	20	4-52	10	0	7-57	11	45	22-75	16	31	7-49	53	25	14-38							
SIOUX VALLEY MEM HOSP CHEROKEE IA 51012	IA-116	450	13	11-20	31	32	20-55	26	31	14-48	17	0	6-45	23	30	14-50	16	44	23-69	8	13	3-58	40	20	11-38							
SNIFF MARY FRANCES MEM HOS NEWTON IA 50208	IA-117*	490	13	8-17	35	26	10-40	20	45	13-52	10	10	4-53	30	23	11-41	13	31	20-69	10	10	2-51	47	23	11-35							
SPENCER MUN HOSP SPENCER IA 51301	IA-118*	806	7	7-14	76	8	12-34	23	30	15-52	6	33	4-66	34	32	12-41	19	21	23-65	6	0	3-66	59	24	12-35							
ST ANTHONY REG HOSP CARROLL IA 51401	IA-119	509	10	9-17	35	17	10-39	15	27	14-60	10	0	2-49	27	37	11-43	16	50	23-69	8	0	1-56	63	21	15-38							
ST FRANCIS HOSP WATERLOO IA 50702	IA-120*	1141	11	8-15	68	22	14-37	47	28	19-46	43	14	10-36	50	24	13-37	33	55	24-57	18	17	5-43	80	19	13-33							
ST JOSEPH COMM HOSP NEW HAMPTON IA 50659	IA-121*	309	20	13-23	18	39	15-57	9	44	12-68	4	50	2-75	25	40	9-41	16	19	24-70	8	75	6-67	33	39	16-48							
ST JOSEPH HEALTH & REHABIL OTTUMWA IA 52501	IA-122*	744	12	8-16	36	28	15-46	24	25	14-50	15	20	7-48	47	15	12-36	27	48	21-57	8	50	2-56	62	27	11-33							
ST JOSEPH MERCY HOSP CLINTON IA 52732	IA-123	886	14	10-18	59	19	12-36	47	32	15-41	34	29	9-38	50	22	12-35	41	34	25-55	27	26	10-44	112	15	13-30							
ST JOSEPH MERCY HOSP MASON CITY IA 50401	IA-124	2350	9	7-14	153	18	15-32	73	34	19-41	53	13	8-31	108	23	16-33	69	35	26-50	40	23	8-36	144	15	13-29							
ST JOSEPH'S MERCY HOSPITAL CENTERVILLE IA 52544	IA-125	440	16	10-19	20	30	12-52	23	39	16-54	11	18	7-56	21	33	12-50	20	40	22-63	12	17	6-54	53	15	10-33							
ST LUKE'S HOSP DAVENPORT IA 52803	IA-126*	1781	11	9-15	129	27	17-36	66	21	17-40	55	16	10-33	94	19	16-34	60	32	27-52	34	9	5-33	137	17	11-26							
ST LUKE'S METHODIST HOSP CEDAR RAPIDS IA 52402	IA-127	3464	9	8-14	225	14	16-32	93	26	20-40	73	22	11-32	132	27	16-32	133	31	30-48	54	19	9-34	197	13	14-28							
ST LUKES MED CENTER SIOUX CITY IA 51104	IA-128	2877	10	8-15	285	18	19-34	54	39	19-44	43	37	9-35	118	29	18-35	59	51	26-52	38	34	10-39	214	18	14-28							
STEWART MEM COMM HOSP LAKE CITY IA 51449	IA-129	481	11	9-18	25	12	6-39	17	41	16-59	13	8	8-54	20	35	14-52	20	45	23-65	14	7	9-54	53	8	10-33							
STORY CITY MEM HOSP STORY CITY IA 50248	IA-130	177	15	10-22	3	67	4-85	7	57	7-68	3	33	3-84	8	25	5-60	4	75	11-87	7	14	3-61	17	12	12-53							
STORY CO HOSP NEVADA IA 50201	IA-131	178	16	11-23	4	50	9-85	5	0	6-74	2	0	1-89	15	33	10-53	9	56	17-75	4	50	3-77	27	19	13-46							
TRINITY REG HOSP FORT DODGE IA 50501	IA-132*	1606	11	8-15	125	9	13-32	53	42	17-42	46	24	9-34	64	25	14-35	60	37	28-54	20	20	7-44	143	22	12-27							
UNIVERSITY OF IOWA HOSP C IOWA CITY IA 52240	IA-133	3700	8	7-14	388	15	20-34	79	16	18-38	57	28	13-37	70	26	15-36	97	36	27-47	40	28	13-42	129	17	13-29							
VAN BUREN CO MEM HOSP KEOSAUQUA IA 52565	IA-134	186	17	9-21	6	67	9-75	1	0	0-97	2	0	0-93	18	22	10-49	8	50	16-76	2	0	0-90	15	33	7-49							
VETERANS MEM HOSP WAUKON IA 52172	IA-135	239	17	10-21	13	54	15-64	12	42	10-59	9	11	5-58	21	33	10-47	6	83	14-81	11	27	4-51	26	19	10-43							
WASHINGTON CO HOSP WASHINGTON IA 52353	IA-136	304	15	11-21	16	38	9-52	18	22	16-57	8	25	4-59	25	36	11-44	21	33	23-63	8	25	3-58	40	13	9-35							
WAVERLY MUN HOSP WAVERLY IA 50677	IA-137	378	16	9-18	20	30	7-44	25	28	17-52	14	7	6-49	18	39	10-49	13	38	19-68	13	46	6-52	23	17	10-46							
WAYNE CO HOSP CORYDON IA 50060	IA-138*	259	12	10-20	16	25	14-59	3	67	3-83	5	20	2-69	4	0	3-76	10	50	19-74	11	18	5-53	42	14	13-39							
WINNESHIEK CO MEM HOSP DECORAH IA 52101	IA-139	516	13	11-20	35	29	18-50	15	20	16-62	15	7	9-52	40	25	13-40	21	38	22-63	9	11	4-56	61	20	12-34							

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
SHENANDOAH MEM HOSP SHENANDOAH IA 51601	5	60	2-71	2	0	2-90	6	0	1-62				40	8	2-20	7	0	0-67	6	0	0-100	28	0	1-24	17	0	0-46			
SIOUX VALLEY MEM HOSP CHEROKEE IA 51012	1	100	3-99	13	15	15-64	6	0	1-62				58	5	2-17	7	0	0-66	2	0	0-100	41	2	1-18	26	0	0-26			
SKIFF MARY FRANCES MEM HOS NEWTON IA 50208	5	20	2-71	5	20	8-77	1	0	0-100				53	6	2-16	29	7	0-24	5	0	0-100	25	4	1-24	12	0	0-72			
SPENCER MUN HOSP SPENCER IA 51301	2	100	3-91	5	20	8-78	32	9	2-24	10	0	0-100	102	2	2-12	80	1	0-14	22	0	0-83	42	0	2-19	93	0	0-8			
ST ANTHONY REG HOSP CARROLL IA 51401	3	33	1-82	2	0	8-96	27	4	3-29	2	0	0-100	63	0	1-14	41	0	0-20	5	0	0-100	30	0	1-21	34	0	0-18			
ST FRANCIS HOSP WATERLOO IA 50702	14	36	3-50	12	25	13-65	34	9	5-29	2	0	0-100	114	5	2-11	72	7	1-14	19	5	0-66	82	4	2-13	105	0	0-8			
ST JOSEPH COMM HOSP NEW HAMPTON IA 50659	7	29	14-78	7	43	18-82	14	7	2-40	.	.	.	47	6	2-18	16	0	1-35	4	0	0-87	32	3	1-21	6	0	0-95			
ST JOSEPH HEALTH & REHABIL OTTUMWA IA 52501	3	0	1-82	4	25	8-84	28	14	5-32	1	0	0-100	80	6	2-14	43	12	2-20	6	0	0-100	47	2	2-17	78	3	0-9			
ST JOSEPH MERCY HOSP CLINTON IA 52732	5	60	2-71	18	39	19-63	32	9	2-24	1	0	0-100	91	7	2-13	35	3	1-21	2	0	0-100	79	4	2-13	39	3	0-17			
ST JOSEPH MERCY HOSP MASON CITY IA 50401	9	33	8-65	18	33	18-62	69	17	4-20	39	3	0-34	286	6	3-10	97	1	1-12	28	0	0-68	143	3	3-11	277	1	0-4			
ST JOSEPH'S MERCY HOSPITAL CENTERVILLE IA 52544	6	33	7-74	1	0	0-97	15	20	1-37	.	.	.	60	5	2-15	14	14	0-39	2	0	0-100	34	9	1-20	13	0	0-60			
ST LUKE'S HOSP DAVENPORT IA 52803	19	21	10-53	8	75	18-79	48	10	3-21	2	0	0-100	162	7	3-11	73	7	2-15	21	0	0-90	272	8	3-8	127	1	0-7			
ST LUKE'S METHODIST HOSP CEDAR RAPIDS IA 52402	20	15	10-53	32	41	20-55	99	5	4-17	41	2	0-21	329	4	3-9	196	2	1-10	29	0	0-83	361	6	3-8	251	1	0-5			
ST LUKES MED CENTER SIOUX CITY IA 51104	10	30	8-63	19	32	22-66	108	7	5-17	7	0	0-100	343	4	3-9	228	2	1-10	35	0	0-62	178	8	3-10	317	2	1-4			
STEWART MEM COMM HOSP LAKE CITY IA 51449	8	0	4-62	2	50	5-94	20	5	2-33				61	5	2-16	16	6	0-35	7	0	0-100	25	8	1-24	31	0	0-22			
STORY CITY MEM HOSP STORY CITY IA 50248	6	33	9-76				-	-					9	0	1-49				2	0	0-100	13	0	1-39	6	0	0-94			
STORY CO HOSP NEVADA IA 50201	2	0	1-90	1	100	2-98	5	40	4-72				14	0	0-39	5	20	0-74				14	0	1-37	9	0	0-64			
TRINITY REG HOSP FORT DODGE IA 50501	13	15	8-58	8	38	11-71	91	9	3-17	10	0	0-100	161	4	2-10	104	2	2-13	26	0	0-69	74	5	2-13	165	1	0-6			
UNIVERSITY OF IOWA HOSP C IOWA CITY IA 52240	68	12	8-37	7	43	9-71	45	16	4-23	344	0	0-2	216	9	5-13	124	1	1-12	32	3	0-21	374	6	3-8	207	1	0-5			
VAN BUREN CO MEM HOSP KEOSAUQUA IA 52565	1	100	0-97				2	50	0-96	1	0	0-100	13	8	2-41	2	0	0-100				16	0	1-34	4	0	0-99			
VETERANS MEM HOSP WAUKON IA 52172	1	0	1-98	3	33	8-89	13	8	1-41				23	9	1-28	15	7	1-36	1	0	0-100	13	8	1-39	11	0	0-64			
WASHINGTON CO HOSP WASHINGTON IA 52353	2	50	2-90	1	0	2-98	2	50	1-89				38	5	2-20	2	0	0-94	4	0	0-100	32	3	1-20	4	25	0-99			
WAVERLY MUN HOSP WAVERLY IA 50677	5	0	7-77	1	0	0-97	21	0	2-31				48	6	1-17	26	0	0-26	3	0	0-100	10	30	0-47	31	0	0-28			
WAYNE CO HOSP CORYDON IA 50060	4	0	1-77	2	0	2-90	9	33	2-51	.	.	.	27	4	1-24	6	0	0-65	3	0	0-100	35	3	2-21	16	0	0-46			
WINNESHIEK CO MEM HOSP DECORAH IA 52101	11	64	12-67	5	60	18-89	7	14	1-57				49	0	1-17	17	6	1-33	8	0	0-94	30	0	1-22	21	5	0-28			

*Written Comments Not Submitted.

Allen Memorial Hospital
"For Love of Fellow Man"

LARRY W. PUGH, M.A., FACHE
President

October 14, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: HCFA Mortality Data Verification

Dear Doctor Roper:

We have checked the detailed listing of mortalities for Allen Memorial Hospital (AMH) reviewed for accuracy.

Category # 1 Patients Who Expired at Allen Memorial Hospital
HCFA Count: 161 Correct Count: 160
All patients with the same discharge date as the date of death were patients who expired at Allen Memorial Hospital with the exception of one patient:

HIC #	Name	Diagnostic Category	Age	Sex	Date of Adm	Date of D/C	Date of Death
[redacted]		HM	092	F	1/6/86	1/16/86	1/16/86

This patient information is identical to that patient "[redacted]" immediately following "[redacted]" on the detail listing. Therefore, in diagnostic category HM, one patient has been double counted.

Category # 2 Patients Who Expired Within 30 Days of Admission But NOT At Allen Memorial Hospital
HCFA Count: 50 Correct Count: 50
The dates of admission and discharge for all patients in this category are correct.

Please note that in this category the patients did not expire while hospitalized at Allen Memorial Hospital, therefore within the hospital information system, we have no way of verifying the dates of expiration listed. We could have contacted the attending physicians to verify death after discharge but this step has not been performed to date based on the fact Allen Memorial Hospital is within the range of predicted mortality rates for all categories.

Yours sincerely,

Larry W. Pugh
LWP/jg

1825 Logan Avenue • Waterloo, Iowa 50703 • 319 / 235-3987

Buena Vista County Hospital
1525 West Fifth Street
Storm Lake, Iowa 50588
TELEPHONE 712-732-4030

COMMENTS ON THE HCFA MORTALITY DATA
Buena Vista County Hospital, Storm Lake, Iowa
Hospital ID number = 160066

Data Verification

The data used by HCFA indicate that a total of 78 Medicare patients admitted to Buena Vista County Hospital died within 30 days of admission. Of these, 66 died while still a patient of the hospital, while 12 died after discharge. Our own records indicate that 850 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Buena Vista County Hospital is correct. Our own records also indicate that of the 66 Medicare patients who died within 30 days of admission while still an inpatient, 1 was still alive at the time of discharge. It is impossible to determine the percentage of the 12 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

In 2 of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. After correcting the errors in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate stays the same.

Results of Prelimary Medicare Record Review

1. In the category GY where the actual rate is 100% based on the statistics of 1 patient, the coding used for this analysis is in error. Instead of the principal diagnosis code being 621.8, which is how HCFA has it recorded, it should be V66.0, which is what our records show as being billed. Changing this patient would leave us with no patient in this category.

2. In the category CE all 13 patients who died within 30 days of admission were admitted with poor or guarded prognosis and died in the hospital. 6 of the 13 died within the first day of admission.

Enclosed is the computer printout sent with our rates. The 2 patients in error are highlighted for your correction. Thank you for the opportunity to comment.

Sincerely,

Mary Beth Sorensen RN
Utilization Management

Buena Vista County Hospital
Storm Lake, Iowa

Provider Number: 16-0066

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

Burgess Health Corporation

1600 Diamond Ave., Onawa, IA 51040 (712) 423-2311

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

In our review of HCFA's data on mortality rates, it appears that the total number of deaths agree with our records. However, mistakes were found in two areas:

1. In patient listed as dying on one day post discharge, died at midnight in Burgess Memorial Hospital (patient ID# [redacted] therefore this patient is not a post hospital death.
2. Several diagnostic categories were incorrectly listed:
   a) Patient #[redacted] a post hospital death, the death certificate showed CHF(HM) and HCFA listed GC.
   b) Patient #[redacted] HCFA listed low risk heart disease, death certificate showed a severe heart disease, listed correctly as post hospital death.
   c) Patient #[redacted] death certificate listed CHF, HCFA listed as GI - post hospital death.
3. Three (3) patients in diagnostic category UN, died of cancer (CA) and this is listed as cause of death on death certificate. The reason for the last hospitalization was a complication secondary to the cancer in two of the cases. ID numbers are as follows: a) #[redacted]
   b) #[redacted]
   c) #[redacted]

We feel it is significant that of the 64 in-hospital deaths, 30 of those patients were current nursing home residents who were transferred to Burgess Memorial Hospital because of severe deterioration in their condition. This accounts for 47% of our in-hospital deaths. We feel that this in no way reflects upon Burgess Memorial's quality of care, but on the high number of elderly residing in our service area nursing homes who have chronic to life threatening health problems.

It appears as though on post hospital deaths the inaccuracies are due to HCFA using the discharge diagnosis of the last hospital stay rather than the cause of death from the death certificate. We are quite sure this information is available to HCFA through the Social Security system. Regardless of the availability of this information to HCFA it is irresponsible to arbitrarily publicize the last hospital admission diagnosis as the cause of death.

We realize it is difficult to ascertain some things from a chart, however, this does not justify taking gross liberties with the facts when communicating with lay persons.

Sincerely,

Karmon T. Bjella
President

KTB:jp

cc: IHA

BMC Burlington Medical Center
602 N. THIRD ST. / BURLINGTON, IA 52601 / (319) 753-3011

October 21, 1987

Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

The hospital specific mortality data you compiled for Burlington Medical Center (BMC) appear to be accurate. BMC's rates also are well within expected or normal ranges as computed in your predicted rates.

An analysis of the data show the following:

* BMC's actual mortality rates fall within the ranges of the predicted mortality rates in all 17 diagnostic categories.

* In 13 of the 17 categories, BMC's actual rates are equal to or below the mid-range of predicted mortality rates.

	Mid-Range Of Predicted Mortality Rates	BMC's Actual Rate
All Causes	13	13
Cerebrovascular Accidents	29	29
Ophthamologic Disease	50	0
Gastrointestinal Catastophes	22	18
Urologic Disease	8	2
Gynecologic Disease	49	0
Low-Risk Heart Disease	6	6
Metabolic/Electrolyte Disturbances	23	14
Orthopedic Disorders	3	2
Pulmonary Disease	21	20
Sepsis	44	25
Severe Trauma	11	8

* In three diagnostic categories, BMC's actual rates exceeded the mid-range of predicted mortality rates by only 1, 2 and 4 percentage points, respectively.

	Mid-Range	BMC Actual
Cancer	26	27
Severe Chronic Heart Disease	24	20
Severe Acute Heart Disease	40	44

* Only one diagnostic category, renal disease, exceeded the mid-range of predicted mortality rates to any significant degree (23 percentage points). However, the actual rate of 60 percent was still 11 percentage points below the high end of the range of predicted mortality rate (71 percent). Also, it should be noted that the 60 percent mortality rate for this category was based on an extremely small number of cases--only five cases. With this small volume, the computations are not statistically meaningful.

BMC is a not-for-profit regional medical center, receiving referrals from a six-county area. The medical center has 402 beds, including 24 Skilled Nursing Facility (SNF) and 125 Intermediate Care Facility (ICF) beds. A high percentage of our patients are severely ill as compared to smaller primary care hospitals in the surrounding counties. BMC does not have a chronic dialysis unit and therefore the renal disease patients we see frequently are end stage, quite septic and near death at the time of admission.

It should be pointed out that the use of mortality rates alone to measure quality of care is of limited value. Mortality rates, without other information that can only be obtained by closely examining the patient's medical record, fail to consider the patient's general health status, the stage of the patient's illness, co-morbidity, the patient's psychological condition, and family support. An appropriate assessment of an individual hospital's performance would include an examination of a number of other quality indicators, such as infection rates, frequency of readmissions, in-hospital accident rates and patient transfers.

Thank you for this opportunity to respond to your report.

Sincerely,

Glen L. Heagle

Glen L. Heagle
President and C.E.O.

GLH/dh

CCMH

DENNIS J. RENANDER
Administrator

Cass County Memorial Hospital

1501 East 10th Street Atlantic, Iowa 50022 712-243-3250

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Gentlemen:

The data compiled by the Health Care Financing Administration on Cass County Memorial Hospital is accurate with regards to the patients who died in our facility. For those who died within 30 days of their last admission, it is not possible to verify the accuracy of this data being "credited to Cass County Memorial Hospital." This data represents 33% of the total reported deaths for the hospital.

In assuring the hospital's performance, mortality is only one indicator of many variables which are needed to appropriately address the quality of care. Cass County Memorial Hospital offers a wide variety of health care services, including acute inpatient, skilled nursing, outpatient, home health care and hospice to a rural population where approximately 20% of the residents are elderly. It is worthy to note that over 60% of the hospital's services are provided to the elderly. This leads to higher intensity and severity of patient illnesses based on our population. Because the intensity of service and severity of illness are not accounted for in the mortality data, this leads to erroneous and misleading interpretations of data that is being reported.

It is also important to take into consideration that when tabulating discharges within 30 days of discharge, that data may not be statistically valid. In the life of an 85 or 90 year old person with co-morbid conditions, 30 days may represent a long period of time. To assume that a patient's death was directly related to the recent hospital stay and award that death posthumously to hospital statistics is grossly unfair to small and rural hospitals serving the elderly.

Finally, Cass County Memorial Hospital has active committees on utilization review, infection control, and quality assurance. These committees of hospital and medical staff work to assure that quality care is provided to all patients, and their work is not limited only to patients who have died. These committees have been and will continue to be an integral part of our review to assure that quality health care is provided to all those we are privileged to serve.

Thank you for your attention to this information, and I trust it will be helpful in preparing your final reports.

Respectfully submitted,

Dennis J. Renander
Administrator

DJR/mp

cc: Iowa Hospital Association

CHARTER COMMUNITY HOSPITAL
1818 48th Street
Des Moines, Iowa 50310
(515) 271-6000

September 25, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

Charter Community Hospital has received and reviewed the patient mortality information specific to this institution. The Hospital ID No. is [redacted] After a review of the pertinent information, we have found that there is only one discrepancy which appears to be evident. This involves patient ID No. [redacted] The principle diagnosis which your organization has listed is 0389 and a review of our records indicates that the principle code should have been 276.5. All other information appears to be accurate.

Thank you for your attention to this matter.

Sincerely,

Dennis Janssen
Administrator

DJ/jd

cc: Judy Ebarb, Quality Assurance Coordinator

Community Memorial Hospital

Telephone
712-728-2428

Box 188, 8th Avenue W.
Hartley, Iowa 51346

Mrs. Donna Towne
Administrator

Re: HCFA's selected mortality information.

DATE: October 15, 1987
PATIENT ID #: [redacted]
ADMISSION DATE: 12-26-85
DISCHARGE DATE: 01-01-86
HOSP. PROVIDER #: 160071

William L. Roper, M.D.
Department of Health & Human Services
Washington, D.C. 20201

Mr. Roper:

Regarding HCFA's classification of the above patient: The Iowa Foundation for Medical Care (IFMC) randomly reviewed the medical record of this gentleman for validation of the DRG on June 12, 1986. The IFMC reviewing physician, on July 28, 1986, changed the principal diagnosis from 'dehydration' to 'staph aureus pneumonia'. The ICD-9-CM codes, therefore, were changed from 276.5 to 482.4. This change also resulted in a change of the DRG from 296 to 079.

You have incorrectly placed this gentleman in the diagnostic category of ME (metabolic/electrolyte imbalance). He should be placed in the category of PN (pulmonary disease). Therefore, your data is incorrect that we have a 100% mortality in the metabolic/electrolyte imbalance category.

Sincerely,

B R Kallepalli

Dr. B.R. Kallepalli
Community Memorial Hospital
Hartley, Iowa 51346

Comments on the H.C.F.A. Mortality Data
Decatur County Hospital, Leon, Iowa 50144
Provider Number: 16-0055

The data used by H.C.F.A. indicate that 353 Medicare patients were admitted to Decatur County Hospital in 1986. Our own records reveal 585 Medicare patients were admitted. Granted, some of the admissions are the same beneficiary admitted more than once during the year. However, it is impossible for us to verify H.C.F.A. data on admissions as we are unaware of any patient admitted to our hospital who was later admitted to another hospital. As H.C.F.A. indicated, data was based on the last hospital admission of each Medicare beneficiary in 1986. As a result, we are unable to verify the 19% mortality rate assigned to Decatur County Hospital (number of deaths compared to admissions) without access to detailed information available to H.C.F.A.

H.C.F.A. reported that there were 68 deaths of Medicare patients at Decatur County Hospital within 30 days of admission. There were 54 deaths reported while the patients were yet hospitalized and 14 deaths after discharge. Our own records are consistent with H.C.F.A., i.e. 54 deaths occurred in the hospital.. However, it is impossible to determine the number of patients who died after discharge as that is not included in the patient's hospital medical record.

There were two errors in the recording of Medicare deaths. On one record, two numbers were transposed, resulting in an erroneous diagnosis in the category severe chronic heart disease - HM (coded 428.1). The correct diagnosis was in the category pulmonary disease - PN (coded 482.1). This error resulted in a significant percentage change in both categories for our hospital as the total number of cases per category is small, i.e. considerably less than 100. The mortality rate for diagnostic category HM was changed from 73% to 70%. The mortality rate for diagnostic category PN was changed from 29% to 30% by the correction in diagnostic category.

A second error occurred as a result of a mistake in designating primary diagnosis for admission. The patient was transferred from an acute care hospital to Decatur County Hospital skilled nursing unit. The patient was treated at the previous facility for a cerebrovascular accident (436). The patient was terminal and transferred to skilled nursing (V57.89). Thus, the diagnostic category cerebrovascular accident - CE, is reduced by one patient. The mortality rate for CE was changed from 60% to 58%. It is noteworthy that this patient was also diagnosed with inoperable cancer of the pelvis.

As was stated in the letter accompanying the H.C.F.A. data, "we can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals". Thus, the Medical Staff and quality assurance committee of Decatur County Hospital used the H.C.F.A. data as a screening tool directing their further review of patient deaths. The hospital Medical Staff reviews monthly the medical records of all patients having died during the month. This is a case by case, concurrent review which is a voluntary activity at Decatur County Hospital to assure quality of care. A retrospective review of the H.C.F.A. data about Medicare beneficiaries who died in the hospital was consistent with the findings of the quality assurance committee and Medical Staff. There were no findings to suggest problems with the quality of health care provided the patients at Decatur County Hospital.

The results of the hospital's Medicare record review affirm the significance of descriptors <u>not</u> used in the H.C.F.A. data, i.e. status at admission and severity

of illness. Additionally, it is very difficult to realize how the "presence or absence of selected comorbidities" was reflected in the range of predicted mortality rates for Decatur County Hospital.

In the category of cerebrovascular accidents (CE), there were 11 deaths (corrected), with an average age of 78 years. Eight of the eleven were unresponsive or unconscious at admission and 10 of 11 were in poor condition. Undoubtedly, status at admission is a significant variable when looking at the outcome - death. In terms of severity of illness, all eight patients who died in the hospital remained unresponsive/unconscious until death. Two patients died after discharge from Decatur County Hospital. At the family's request, one patient was transferred the same day as admission to a tertiary acute care hospital and died 5 days later. This patient was unable to speak or move at admission and had no comorbid conditions. The other patient was transferred to a nursing home in terminal condition and died 6 days later. Of the 11 patients, 10 had comorbid conditions of significance to the patient's general health status, i.e. 3 had congestive heart failure, 3 had diabetes·mellitus, 5 had arteriosclerotic heart disease, 1 had pneumonia, and 1 had hypertension. Two patients died within 24 hours of admission. The severity of the patient's stroke, as well as his/her general health status, impaired by comorbid conditions, definitely impacted the outcome of treatment.

In the category severe chronic heart disease (HM), there were 7 deaths (corrected), with an average age of 83 years. Status at admission for these seven patients is as follows: 2 were in fair condition, 4 were in poor condition, and 1 was in critical condition. Of those 7 patients, 3 had been hospitalized at Decatur County Hospital two or more times during the previous 12 month period. All of the patients had comorbid conditions significantly altering their health status, i.e. 5 had arteriosclerotic heart or cerebrovascular disease, 4 had diabetes mellitus, 1 had chronic obstructive pulmonary disease, 3 had pulmonary edema or embolus, 1 had bronchopneumonia, 1 had unresectable aortic aneurysm, 1 had cardiogenic shock, and 1 had cardiorespiratory arrest. The conditions of cardiogenic shock and cardiorespiratory arrest occurred in different patients. Of the 3 patients who died after discharge from Decatur County Hospital, two were transferred to nursing homes in poor and terminal condition. The other patient was transferred to a tertiary acute care hospital the same day of admission in critical condition. She had arrested one time and was resuscitated prior to transfer. She died 28 days later. Again, significant variables for fatal outcome appear to be status at admission, severity of disease, and comorbid conditions.

In both categories, HM and CE, mortality rates at Decatur County Hospital exceeded the predicted range or mortality rates. It is acknowledged that both categories are high risk. The hospital staff's medical record review heightened suspicions about the significance of status at admission, severity of illness, and comorbid conditions as they relate to the outcome of death. It points to an imperative need for further inquiry and study. For example, additional questions to answer are: What ages of patients strongly correlates with a death outcome?; Does admission status and severity of condition statistically correlate with outcome (either survival or death)?; Which comorbid conditions correlate with a fatal outcome?; Which variables (descriptors) have the greatest statistical significance when compared to outcome (death or survival)?.

With access to the H.C.F.A. data, this institution would be able to statistically analyze descriptors for correlation and comparative significance with outcomes. However, statistical analysis is only an adjunct to the many quality assurance activities of Decatur County Hospital and does not replace any one activity, i.e. concurrent and retrospective audits and reviews, trend analysis, voluntary accreditation, problem solving and evaluation, standards of care, and procedure review.

Finally, there are some additional factors about Decatur County Hospital and it's service population which result in higher mortality rates. Of the 9,265 residents in Decatur County, 19% are 65 years of age or older. Of the 1,170 admissions to Decatur County Hospital, 50% were Medicare beneficiaries. The average age of Medicare admissions was 80.6 years. In the H.C.F.A. data, the average age of reported deaths was 81.2 years. Life expectancy, based on the years of birth of current Medicare beneficiaries, is approximately 70-72 years (U.S. Bureau of Census, 1983). Within Decatur County there are in excess of 200 nursing home beds. The hospital also provides skilled nursing care, in addition to acute care, in response to population needs. Some conclusions drawn from this data are included as follows. There is a higher percentage of Medicare beneficiaries in Decatur County Hospital service population than in the national population. As the average age of hospital Medicare admissions is in excess of the predicted life expectancy, one would anticipate that Decatur County Hospital patients are experiencing increased incidence of acute and chronic disease with increasing severity necessitating hospitalization. Also, the potential for death is increasing. The population mix is most assuredly skewed in the county by the number of nursing home residents experiencing debilitating and incapacitating health conditions. The skilled nursing services also increases the mortality rate as the patients are receiving care for severely impaired health status and it is often terminal care. For example, in the H.C.F.A. data, 5 of the 8 patients receiving skilled nursing sevices died.

In conclusion, the greater value of this exercise to Decatur County Hospital was to provide feedback to H.C.F.A. on additional descriptors and variables that appear to influence death outcomes. Medical record review confirmed quality of care at Decatur County Hospital.

October 19, 1987

DesMoinesGeneral
Osteopathic
Hospital

William L. Roper, M.D., Administrator
Health Care Financing Administration
Dept of Health and Human Services
Baltimore MD 21207

Dear Doctor Roper:

We applaud the study conducted by the Health Care Financing Administration using mortality information on Medicare patients treated at all acute care hospitals in the United States during 1986. A study of 6.5 million admissions can produce extremely reliable data on a wide range of healthcare issues. We are truly in the midst of an information revolution, one that will have a major impact on the future delivery of medical care in the United States.

In the release of your findings, you are providing the American public with one of the few QUANTITATIVE measures available for judging hospital care. Readers will be able to determine how many deaths occurred during or after admission to the hospitals of their communities. We sincerely hope, however, that the public will not equate this information with a QUALITATIVE measure of the care available in the community. There are simply too many factors that have an impact on the outcome of hospitalization.

First, and most notable, is the absence of a SEVERITY OF ILLNESS index to adjust mortality data. Without adjusting the data to reflect the illness of patients presenting for admission to the hospital, the mortality rates of various hospitals are due to different causes. For example, hospitals that have developed "centers of excellence" in cardiac care will experience higher mortality in severe acute heart disease, primarily because their reputation for excellence of care attracts patients experiencing heart attacks. A patient presenting during myocardial infarction is at a high risk of dying. Conversely, the small community hospital in the same general area may have a low mortality rate for severe acute heart disease, primarily because those patients presenting at the hospital are transferred to the specialty center after they are stabilized. Quality of care is neither better nor worse at either hospital; the hospitals simply have different severity of illness indexes.

Second, the care available at a hospital is only as good as the members of its medical staff. The medical staff provides the actual hands-on care, controls the effectiveness of the quality assurance programs, and condones or disciplines medical staff members whose practice patterns do not meet or exceed established standards. An accredited hospital has met the same standards for nursing care, infection control, dietary, ancillary services, and staffing as any other accredited hospital. It is the involvement and competence of the medical staff that will affect the quality of care provided at the hospital.

603 EAST TWELFTH STREET DES MOINES, IOWA 50307 (515) 263-4200

The public deserves to have as much information as possible about the aspects of medical care that may affect the health of a person seeking medical care. My advice to anyone seeking care: evaluate the training and board certification of your physician, interview the physician to determine how many times the physician has cared for or treated a patient with your diagnosed condition. Find out which hospital the physician prefers and why, and then discuss the mortality data with the physician to learn why a particular hospital in your community has performed as it has.

The vast majority of healthcare providers in this country, physicians and hospitals alike, are dedicated and highly competent. I would not like the American public to misconstrue any of the healthcare information that will increasingly become available to them. I firmly believe that excellent healthcare is available throughout the country in medical offices and hospitals in every community.

Sincerely,

William I. Cairns

William I. Cairns, FACHE, FCOHE
President

WIC:be
cc: Iowa Hospital Assn

DEWITT COMMUNITY HOSPITAL
1118 11TH STREET • DEWITT, IOWA 52742 • 319-659-3241
OFFICE OF THE ADMINISTRATOR

ATTACHMENT 4

COMMENTS ON THE HCFA MORTALITY DATA
DeWitt Community Hospital, Dewitt, Iowa
Medicare Provider Number 160062

Data Vertification

The data used by HCFA indicate that a total of 34 Medicare patients admitted to DeWitt Community Hospital died within 30 days of admission. Of these, 27 died while still a patient of the hospital, while 7 died after discharge.

Unique Services Resulting in Higher than Average Mortality.

While DeWitt Community Hospital is quite pleased to note that our actual mortality rate is within the range of predicted mortality rates in all of the diagnostic categories, we are still concerned with the usage of this raw data as inferring to the public that this data be used as a tool for indicating quality care.

Specifically, several of our concerns are as follows:

1.) As a small hospital we are dealing with small numbers that may cause percentage reports to not indicate a true picture, i.e., two categories indicates only one case thus the percentage is either 0% or 100% (both results were 0%).

2.) As a hospital we, in addition to acute care, also care for patients as a licensed skilled nursing facility (SNF) and intermediate nursing facility (ICF). By offering this range of service we are allowing ourself exposure to increased mortality rates. In fact one of the deaths listed with our statistics was a transfer into our skilled unit from another hospital that did not provide the service.

3.) The mortality rates do not reflect the severity of illness upon admission. The patient's general health status is not considered and the stage of the person's illness is not considered.

The Finley Hospital
350 N. Grandview Ave.
Dubuque Iowa 52001
(319) 582-1881

October 28, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Medicare Mortality Rate

Dear Sirs:

Inasmuchas I had to call your office in order to obtain our hospital specific medicare mortality rates and only received the information approximately 10 days ago, I needed additional time to review and analyze our data. Therefore, I hope and I expect that you will accept these comments even though they are not received in your office by the deadline which is today.

After analyzing the mortality data for Finley Hospital, I am only able to account for 80% of the patients listed on our report. Even upon further tracking we are unable to account for 28 patients.

Although our rates appear to be within acceptable or national averages, we would like to make a few comments:

1. We strongly feel that this type of rate publication tends to distort the high quality of patient care rendered within our facility.

2. If one follows mortality rates long enough, they will eventually hit 100%!

3. Finley's share of medicare patients is the highest of any hospital in this area.

4. We would question whether these statistics could be age adjusted mortality rates. We feel that this would present a more realistic picture.

5. As you can determine from the above statistics, we are unable to have control outside of our own facility and, therefore, do not feel that those deaths that occur post-hospital should be included.

Thank you for your attention and consideration of my comments.

Sincerely,

David L. Schaller

David L. Schaller
Director, Medical Staff Services

FLOYD COUNTY MEMORIAL HOSPITAL
11TH STREET AND SOUTH MAIN • CHARLES CITY, IOWA 50616 • (515) 228-6830

JAMES D. SCHNECKLOTH
Administrator

October 15, 1987

The Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Administrator:

This letter will advise you of our comments about the intended release of nationwide hospital mortality data. We received your compilation of hospital specific numbers on September 24.

For 1986 this hospital had 683 Medicare discharges compared to your reported 481. The HCFA data included only the final discharge of the year, so some patients had more than one admission. Of 683 total admissions we had 73 deaths reported. Of the 73 deaths, 56 occured in the hospital in acute or swing beds. The remaining 17 deaths occured at home, nursing home or other facility. Of the total of 73 deaths, 12 patients were 90 or older and 45 patients were age 80 or older. Of the 73 deaths 58 were in very high risk categories including such diagnoses as cancer, severe acute heart disease, renal disease, stroke and severe trauma.

Our hospital serves a rural population with a significant number of elderly persons. Medicare patients account for 55% of our admissions and 65% of our patient days. The acuity level or severity of illness with Medicare patients is quite high.

With the above data in mind, our comments are as follows:

(1) It's very difficult to draw institution specific conclusions about our data since there is not a measurement of the severity of illness of the 73 cases. Our own internal review leads us to believe that we dealt with some very serious cases where the outcome would normally be anticipated. The lack of a severity index may result in a report that has little validity or significance.

(2) The high proportion of our cases in substantial risk categories would tend to increase the liklihood of death. Also a number of cases with multiple complications would

add to that likelihood. Variation in these factors make data comparisons between hospitals less valid and meaningful.

(3) Some deaths occuring at home or in a nursing home cannot be evaluated by our hospital. We cannot be sure that the death was from the original diagnosis or from a new diagnosis.

(4) We have no feeling for the validity of "predicted mortality rates". It would seem that severity of patient illness would have a significant impact on predicted mortality.

In summary, we believe that severity of illness has a major impact on mortality of the aged. We believe that the methodology does not adequately measure complications and severity. Members of the public will be able to access data that may be skewed to the favorable or unfavorable side without a true meausure of the quality of care.

Sincerely,

James Schneckloth

James Schneckloth
Administrator

JS:js

Mary Greeley Medical Center

117 Eleventh Street
Ames, Iowa 50010
515-239-2011
Administrator: John D. Worley, Jr

Writer's Direct Dial Number

October 8, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Thank you for sending us the HCFA selected mortality information for patients discharged from Mary Greeley Medical Center. We do appreciate your sharing this information prior to public release

I have reviewed a sample of the patients listed and did not find any errors of admission or discharge dates.

Our chief concern about these statistics is that they do not appear to be age adjusted. For example, our actual mortality rate for patients with severe chronic heart disease is 31% but 56% of the 16 patients were 80+ years at death. Also, the actual mortality rate for patients with severe acute heart disease was 56% but 79% of these patients were 80+ years at death. If this mortality information is not adjusted for age it could be considered misleading and subject to misinterpretation by the public.

The information you have sent does not include physician information. If you are collecting this information I would caution you that it might not be correct. We have found that DRG information we get from our PRO (the Iowa Foundation for Medical Care) contains errors because the information we submitted to them was keyed to the admitting physician rather than to the attesting physician. We are currently trying to correct this problem. Because this is a problem at our hospital I would expect it is common to many hospitals, particularly those who use the same computer software.

We plan to review all the patients who expired after discharge from the hospital. If we find significant problems we will write to you-however, we will not be able to complete the review before your December publication date.

Our Medicare provider number is 1600304.

If you should need to contact me with further information you may call at 515-239-2405. I would like to have a reply concerning the age adjustment statistics so our review committees can deal with the results realistically.

Sincerely yours,

Dolores B. Brown, RRA
Director, Medical Record Services

Hamilton County Public Hospital
800 OHIO STREET, WEBSTER CITY, IOWA 50595, (515) 832-3431

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

We have reviewed the mortality data which you sent to us recently. As a result of that review, we submit to you two important comments:

1) One of the patients listed as being dead is very much alive. He was admitted to our facility again in 1987, and his physician reports that this gentleman has trouble getting payment from Medicare because they keep identifying him as being dead. Identifying information to assist you in correcting this error is included on a separate page.

2) Our mortality rate in the cancer category is higher than the predicted rate because our skilled nursing swingbeds are frequently used to provide terminal care and comfort for patients with cancer.

We appreciate the opportunity to review these mortality statistics, especially the deaths which occurred within 30 days of an admission because that information was not previously available to us.

Sincerely,

Lawrence Massa
Administrator

LM:mn
Enclosure

Hamilton County Public Hospital
800 OHIO STREET, WEBSTER CITY, IOWA 50595, (515) 832-3431

October 23, 1987

To Whom It May Concern:

The patient listed below was incorrectly identified as dead in 1987. He was admitted to our hospital again in 1987 and was very much alive. Please make the necessary corrections:

[redacted]
Medicare ID# [redacted]

HCHC
Henry County Health Center

October 23, 1987

William L. Roper, M.D.
Department of Health and Human Services
Administrator
Washington, DC 20201

HCHC Medicare Provider #16-0106

Dear Doctor Roper:

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

The data used by HCFA indicate that a total of 46 Medicare patients admitted to Henry County Health Center died within 30 days of admission. Of these, 38 died while still a patient of the hospital, while eight died after discharge. Our own records indicate that 357 Medicare admissions occurred in calendar 1986 compared to HCFA's reported 296. The lower number of admissions overstates our mortality rate by 2.7%, which is a 20.6% increase over our actual rate. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the (HCFA reported) number of Medicare patients treated at Henry County Health Center is correct. It is impossible to determine the correctness of the eight patients reported as dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

The eight patients can be categorized in diagnostic groups with severe complications and/or chronic disease of cancer, end-stage renal disease and were most likely the result of patient's wishes with respect to extra-ordinary efforts; therefore, post-discharge deaths were anticipated.

In only one of the categories, SEPSIS, which is expressed in terms of Diagnosis Related Groups (DRGs) does the hospital's actual mortality rate fall outside the range of the predicted mortality rate. The report has not considered the complications and severe underlying chronic disease of this patient. The category is based on the patient's reason for admission to the hospital and not the cause of death. Henry County Health Center does not have the availability of death certificates to review the cause of death as submitted by the physician.

Saunders Park ▪ Mt. Pleasant, Iowa 52641 ▪ (319) 385-3141

VHI Voluntary Hospitals of Iowa
Charter Member

Unique services provided by Henry County Health Center that affect the overall mortality rate are:

1. Henry County Health Center is a Regional Dialysis Facility treating end-stage renal disease patients. These patients were admitted with severe complications which is designated as the "reason for admission". Therefore, seven cases are listed in other diagnostic categories due to the complication of the underlying disease.

2. In meeting community needs, patients with chronic or terminal illness are referred from other hospitals for terminal care, or are often cared for at home and admitted only when the patient is close to death. The severity of illness of these admitted patients are not considered the "average" Medicare patient.

3. Eight severely ill cancer patients were admitted because of complications caused by the disease. Again, the complication was the reason for admission to the hospital. These patients are identified in other diagnostic categories. Ten patients are listed in the category of "all other conditions". These patients would have been categorized in cancer, renal disease or severe heart disease if the underlying disease condition was noted rather than the complication as the reason for admission.

In Summary, Henry County Health Center attributes the differences in mortality rate as submitted by HCFA to the following:

1. The severe underlying conditions or disease of the patients when admitted to the hospital.

2. The community needs for care of the terminally ill patient and as a referral center for those patients.

3. The services provided through the dialysis facility and the challenges that the renal disease patient represents.

4. The actual cause of death is not entered into the data analysis, all data is based on the principle diagnosis (reason for admission to the hospital) as submitted by the physician.

The quality of care of our patients is of utmost concern to the hospital's governing board, management and medical staff. Any indication of potential quality problems including mortality rates that are higher or lower than predicted, leads to a prompt investigation to determine if a problem, in fact, exists. Henry County Health Center routinely reviews all deaths through a mortality review, therefore, the 38 patients listed were previously reviewed for any quality of care concerns. The American Hospital Association and other organizations, including Joint Commission are investigating methods of evaluating hospital quality that rely on measures other than mortality rates and Henry County Health Center looks forward to the results of those efforts.

Respectfully submitted,

R. S. Wellach, M.D.
Chairman, Quality Assurance Committee

RSW:ka

Holy Family Hospital

826 NORTH 8TH STREET - ESTHERVILLE, IOWA 51334

PHONE (712) 362-2631

Comments on the HCFA Mortality Data

The data used by HCFA indicates that a total of 39 Medicare patients were admitted to Holy Family Hospital and died within 30 days of the admission. Of these, 32 deaths occurred while still in the hospital, while 7 died after discharge. Our records indicate 614 Medicare admissions occurred in 1986. Our records indicate that 46 Medicare patients who were admitted to Holy Family Hospital expired within 30 days of the admission. Of these 39 were still in the hospital when they expired. HCFA's data did not include 7 Medicare deaths, all those deaths were in the first half of the year.

The recommended 30 day survival following last admission as a dependent variable for providing performance should not become a measure of the quality of care that a hospital or physician provides. It is impossible to determine of the 7 patients who expired following discharge the percentage who died 30 days following admission, as that information is not included in the medical record. Using the patients last admission fails to indicate any previous hospital stay or change in level of care.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis.

It is important to to acknowledge the limits of the mortality data in order to prevent overreliance on numbers. The range of predicted HCFA mortality rates have not been validated. There are no records of any tests to which the methodology have been submitted to validate its predictors of mortality. The groupings are too broad. There is no consideration for the severity of illiness of the patient. Death rates associated with different principal diagnosis vary greatly. Mortality data should not be used as indicators of the quality of medical care given. All deaths that occur at Holy Family Hospital are reviewed for quality of care by the Medical Care Committee of the Medical Staff.

Holy Family Hospital offers a Hospice program that provides services to patients and families in Emmet county and the surrounding areas. We also have a vascular surgeon who's patients are high risk for surgery and comorbid conditions.

In review of the Medical records of the patients that HCFA identified: (31%) 12 of the 39 deaths were anticipated on admission. (46%) 18 of 39 patients had DNR orders written no either admission or as the patient's condition detoriated. The patient and/or the family requested the DNR order. Of the 39 deaths, 33 patients had underlying conditions, which were included in the listing of the 8 significant comorbid conditions identified by HCFA. 37 of the 39 patients experienced complication which lengthened their stay, or caused their death.

Holy Family Hospital ID# 160002

COMMENTS ON THE HCFA MORTALITY DATA
IOWA METHODIST MEDICAL CENTER

Data Verification

The data used by HCFA indicate that a total of 424 Medicare patients admitted to Iowa Methodist Medical Center died within 30 days of admission. Of these, 370 died while still a patient of the hospital, while 54 died after discharge. HCFA data show 4,083 cases. Our own records indicate 5,365 Medicare discharges occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries. Our re-admission rate is approximately 24%. We have no way of verifying whether the number of Medicare patients treated at IMMC is correct.

Interpretive Remarks

In none of the diagnostic categories does the hospital's actual mortality rate fall outside of the range of the predicted mortality rate.

Review of records for patients in four diagnostic categories revealed that 60% of deaths were expected, i.e., the families had requested no resuscitative measures.

The predicted mortality rates do not reflect case mix, a measure which gives an indication of the level of resources used to care for patients. IMMC's case mix through June, 1986 was 1.4316 and through June, 1987 was 1.4569.

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer				
CE -- Cerebrovascular Accidents				
GC -- Gastrointestinal Catastrophes				
GI -- Gastrointestinal Disease				
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease	29	3	30	2
HM -- Severe Chronic Heart Disease				
HS -- Severe Acute Heart Disease	55	1	56	0
ME -- Metabolic/Electrolyte Disturbances				
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease				
RN -- Renal Disease				
SE -- Sepsis	12	1	12	1
TR -- Severe Trauma				
OP -- Ophthalmalogic Disease				
UN -- Other Diagnoses	73	15	75	13
Total -- All Categories				

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

Gateway Health System
550 South Bluff Boulevard • Clinton, Iowa 52732
319/242-7628

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

RE: Medicare Provider # 160080
Jane Lamb Health Center

Following is Jane Lamb Health Center's response to the mortality data which the Health Care Financing Administration will publish in December, 1987.

The board, management and medical staff of Jane Lamb Health Center stand committed to quality health care. In this spirit we commend the Health Care Financing Administration (HCFA) for publishing quantitative information relative to this topic. Mortality rates, however, by themselves do not measure quality. The appropriate assessment of hospital quality is dependent upon many variables and requires that numerous quality indicators be taken into account of which mortality data is but one. The appropriate use of mortality data is to guide and focus peer review. Quality can only be evaluated through the process of peer review and not through simplistic, statistical comparisons of mortality data.

In addition to our questions about the usefulness of the mortality data in relation to evaluating the quality of health care, we also find some technical methodological errors in HCFA's mortality model. First, the model allows for a 30 day post-admission mortality rate. This means that any patient who dies within 30 days of admission will be included in this study. The patient however, may have been discharged after two weeks and their subsequent death may have been totally unrelated to the condition for which they were hospitalized. We believe including such data will cause to overstate or skew mortality calculations.

Careful analysis also indicates that in many cases the sample

size for a particular category is statistically insignificant and thus the information lacks reliability. For example, in reviewing Jane Lamb Health Center's data, we find that one of the categories only contains three total patients and in fact, two additional categories contain less than 10 total cases. In all three of these instances there is insufficient data for the mortality numbers to be meaningful.

Although the Health Care Financing Administration has attempted to allow for the most notable variables, there are still some significant factors overlooked. For example, certain patient characteristics would naturally lead to higher mortality rates. Jane Lamb Health Center has a skilled nursing unit and is also affiliated with Bluff Terrace and Wyndcrest Nursing Homes. Individuals referred to Jane Lamb Health Center from the skilled unit and the two nursing homes often suffer from multiple complicating conditions and a higher severity of illness than general referrals. Thus, since Jane Lamb Health Center has an established pattern of referrals of this type, it's mortality data will be overstated.

Last, the ability of the HCFA mortality model to detect differences in quality has never been evaluated. In fact, since the analytical methods used to generate the predicted mortality rates have not been publicly made available, the reliability of the model can't be verified.

For all 16 of the HCFA mortality categories, Jane Lamb Health Center falls into the range of predicted mortality rates. Even though Jane Lamb does fall into the range for all categories, we still find some concerns related to the technical methodological basis of this report as well as the philosophical use of the numbers. Our commitment to quality runs deep through our organization. Ongoing medical and nursing quality assurance programs provide the mechanism for peer review, the real key to evaluating quality health care.

Cordially,

Wayne A. Sensor
Vice President Marketing/Planning

WAS/cd

LUCAS COUNTY HEALTH CENTER
Route 3, P.O. Box 43A, Chariton, Iowa 50049 •515-774-2181

COMMENTS ON THE HCFA MORTALITY DATA
Lucas County Health Center Chariton, Iowa

The data used by HCFA indicates that a total of 40 Medicare patients admitted to the Lucas County Health Center died within 30 days of admission. Of these, 31 died while still a patient of the hospital, while 9 died after discharge. Our own records indicate that 417 Medicare admissions occured in 1986.

After review, it was found that 21 of the patients who died while still a patient in the hospital, death was expected at the time of admission or discharge. Many of these patients had "do not rescusitate" requests by the patient and/or their family. The remaining 10 patients who died in the hospital, their death was not really anticipated on admission but they had co-morbidity conditions that would certainly make death a possibility.

After review of the 9 patients who died after discharge, it was noted that 5 were discharged to intermediate care with fair to poor prognosis and death was expected due to chronic conditions. The remaining 4 patients were discharged with good prognosis and information regarding their deaths is not available so no conclusions can be made.

It should be noted that our hospital fell out of the predicted range in only one major diagnostic category and that was renal disease. There were only 2 cases which is insignificant to draw any conclusions.

Thank you for allowing us to comment on this data.

Debbie S. Leyda RN
Utilization Review

MARIAN
HEALTH
CENTER

Office of the President

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Per your request of September 21, 1987, enclosed please find a summation of Marian Health Center's review of the information about Medicare experience in our hospital which you submitted for our comment.

We appreciate the opportunity to review and comment on this information. Please feel free to contact us directly regarding any questions or comments you might have.

Sincerely yours,

Sister Elizabeth Mary Burns

Sister Elizabeth Mary Burns, R.S.M.
President and Chief Executive Officer

SEMB/lp

Enclosure

801 Fifth Street • Sioux City, Iowa 51101 • 712-279-2010
A Division of the Sisters of Mercy Health Corporation

MARIAN HEALTH CENTER

Medicare Provider
No. 160153

COMMENTS ON THE HCFA MORTALITY DATA (C/Y 1986)
Marian Health Center
Sioux City, Iowa

I. Data Verification

Data used by HCFA indicates that 281 Medicare patients died at Marian Health Center within 30 days of admission. An additional 59 patients reportedly died following discharge. Our data confirms the 281 deaths within the hospital. The other 59 patients were indeed hospitalized at Marian, but we have no way to confirm their deaths or cause thereof. We can not verify the total number of cases used in the HCFA data.

II. Interpretive Remarks

. The hospital's mortality rates fall within the predicted mortality range in all 16 categories

. Our mortality rate for all cases is exactly in the middle of the predicted range.

. Since the hospital is the designated center for severe trauma in this region, the low 5% mortality rate in that category appears to be a positive indicator.

. Mortality rates are in the upper normal range for **cancer, neurologic disease** and **severe cardiac problems.** This correlates with the hospital's function as a tertiary referral center for complex cases within these categories.

. In the state of Iowa, Marian Health Center's **case mix index** is second only to the University of Iowa hospitals. This index is not factored into the HCFA results.

. Valid conclusions about quality of care cannot be made utilizing mortality data alone.

. Mortality figures alone cannot be used to make valid comparisons of the quality of care from one hospital to another.

III. Perceived Defects in Information

. No explanation is given for determining predicted range.

. **Principal diagnosis** is sometimes not the same as **cause of death.**

. The study includes deaths outside the hospital without verifying the actual cause of those deaths. Relating them to a previous hospital principal diagnosis lacks validity.

801 Fifth Street • Sioux City, Iowa 51101 • 712-279-2010

A Division of the Sisters of Mercy Health Corporation

- A severity of illness index must be incorporated for validity.

- Not counting deaths more than 30 days after admission, even when patient was hospitalized more than 30 days, is questionable.

- To comply with HCFA, we have converted all data to DRG. We have become comfortable with this system and now a new grouping mechanism has been thrust upon us. This presents problems in verification and comparisons.

IV. Summary

The hospital's mortality rates fall within HCFA's predicted mortality range in all categories. We believe, however, that mortality figures alone cannot determine quality of care or make valid comparisons among hospitals. We have offered suggestions to improve the validity of this process.

The information has been helpful to the hospital. We have many processes of monitoring for quality and we are using these results in our internal review and assessment.

Marshalltown Medical & Surgical Center

3 South 4th Avenue
Marshalltown, Iowa 50158

Telephone:
515/754-5151

October 27, 1987

Hospital Identification # 160001

William Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

I write to you on behalf of Marshalltown Medical & Surgical Center Marshalltown, Iowa, to offer constructive comments regarding the public release of selected mortality information concerning MMSC's 1986 treatment of Medicare patients.

Data identifies 1618 cases with 160 deaths at our facility in 1986 for Medicare patients. Three of the one hundred sixty deaths referenced were calendar 1985 admissions and should not have been considered in the calculation of mortality rates. A fourth case was a transfer from another acute care facility which should have been reflected in the records of the facility of initial admission. The balance of 156 deaths identified in your data for our facility has been verified. It is noteworthy that 41 of those verified deaths occurred following discharge from the hospital and outside the direct influence of our health care.

We are troubled by your data's correlation of cause of death to principal diagnosis. In 36 instances, cause of death does not relate to the admitting diagnostic category. For example, a fractured hip with cause of death being cancer (several days after admission) has been categorized as a trauma death rather than a cancer treatment case. 22.5% of our "Medicare 1986" deaths were not appropriately categorized if cause of death and the reason for last admission should have correlated. Any other alternative certainly detracts from the accuracy of your predicted rates.

It is understood that the width of hospital specific mortality ranges are intended to ensure a 95% confidence factor. In the instance of our facility only 3 of the 16 diagnostic areas have more than 100 cases for the year. Statistical significance is an issue needing more attention especially where there is an unclear correlation between cause of death and the admission categorization.

While our facility falls within 15 of the predicted ranges and below range in the 16th category, we feel that refinement of your methodology is in order. It is unclear how to quantify the age factor impact on predicted ranges. Almost 60% of our mortalities were over the age of 80. 33% of the deaths were over 85 and 2 were over 100 years of age. The "aged" elderly are those at high risk. Without direction as to how the co-morbidity of age has been weighted, it is difficult for our facility to evaluate the predictions yielded by your methodologies.

The opportunity to comment has been sincerely appreciated. We look forward to a continued dialogue so as to make this initiative more meaningful in future years.

Sincerely yours,

MARSHALLTOWN MEDICAL & SURGICAL CENTER

Omar L. Voran
Chief Executive Officer

mja

MERCY HEALTH CENTER
A Division of the Sisters of Mercy Health Corporation

St. Joseph's Unit

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Sir:

We are pleased to have this opportunity to respond to the H.C.F.A. study of Medicare deaths at Mercy Health Center during 1986.

Your report indicates that 2,468 Medicare admissions to Mercy Health Center were reviewed and that 250 of these patients died within thirty days of admission. Further, you reported that fifty of the 250 deaths occurred after discharge from our acute care facilities. We note that our outcomes (patient deaths) are entirely within the predicted ranges for deaths expected.

Our records indicate 3,906 Medicare admissions to Mercy Health Center in 1986. Presumably, the discrepancy between this figure and the 2,468 admissions your study acknowledged is due to the fact that you selected only the last admission to hospitals for the year and have excluded, therefore, 1,438 episodes of care for Medicare patients which did not result in death.

We confirm that the 200 Medicare patients identified in your report did expire on their last admission to our facilities during 1986. At this time, we are not able to confirm all of the deaths of the fifty patients whom you report died after discharge from Mercy Health Center, as our medical records do not include information concerning death after discharge.

Without a more comprehensive description of the billing data H.C.F.A.'s study used to group patients, we are unable to verify the accuracy of the diagnostic labels you assigned for the computation of predicted mortality rates.

Even though our patient outcomes do not appear to be "out of line" with averages or predicted death rates around the country, we derive no great satisfaction from that fact alone. The quality of our care, measured by the numbers of patient deaths we encounter, is a matter of constant concern to us and our internal Quality Management

ST. JOSEPH'S UNIT
Mercy Drive
Dubuque, IA 52001
319 589-8000

ST. MARY'S UNIT
1111 Third Street, S.W.
Dyersville, IA 52040
319 875-7101

XAVIER PARK
Davis and Windsor
Dubuque, IA 52001
319 556-8080

procedures do include case review for each death which occurs. We believe that this is the most accurate and direct way to judge our performance as a hospital.

We understand your motivation in conducting studies such as this one and for the publication of outcomes to the general public. We are firmly committed to the consumer's right to information which will enable him to make informed judgments and choices about his health care and where he will obtain it.

We recommend the H.C.F.A. continue its efforts in the matter of developing information which will at least permit consumers to ask good questions of health care providers. We would also urge that you respond to the very legitimate criticisms of your study methodology by being more attentive to factors which we believe significantly impact the numbers of deaths which occur in any given hospital, e.g., age of the patient, reason for admission, general health status on admission, and the cause of death.

We thank you for this opportunity to provide additional comments to be included in the publication of the mortality data. We commend your worthy objective of enhancing public information. However, we strongly urge that you refine and validate your methodology in the future.

Sincerely,

Sister Helen Huewe, OSF

Sister Helen Huewe, O.S.F.
President

SHH/ims

cc: Representative Tom Tauke
Senator Tom Harkin
Senator Charles Grassley
Art Spies
Dale Schumacher, M.D.

MERCY HOSPITAL

MERCY HOSPITAL Council Bluffs Centennial 1887-1987

October 30, 1987

William L Roper, MD
Administrator, HCFA
Health Standards and Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, Maryland 21207

Dear Dr Roper:

Mercy Hospital received the 1986 Mortality Statistics on October 23, 1987. I would like to take this opportunity to respond to the statistics.

In our review of the information it was noted there are 152 deaths 31 days after admission. Thirty of the deaths occurred after dismissal from acute care. Eleven of the thirty deaths are patients transferred to our Skilled Nursing Unit. At the time of the transfer all were no-code terminal patients. Ten of the thirty patients were transferred to nursing homes after their acute care stay. Five of the remaining patients were discharged to home. Review of the charts revealed appropriate home care agency referrals.

Four of the cases listed as deaths occurring after discharge are in error. Review of the charts found the patients readmitted to acute care with a new diagnosis. The patients expired during the second admission are terminal cases. The readmissions are not identified by HCFA.

The remaining 122 inpatient death cases are reviewed as part of the ongoing Medical Staff Quality Assurance activities.

The opportunity to respond to the 1986 Mortality Statistics is appreciated.

Sincerely,

Mervin Riepe
President

MR:jlc
9430F

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Health Mortality Information
6300 Security Boulevard, Room D-2
Meadows East Building
Baltimore, Maryland 21207

Gentlemen:

This letter serves as Mercy Hospital's formal comment on the Medicare mortality data recently supplied us by the Health Care Financing Administration (HCFA). As part of this comment, we will summarize the statistics provided by HCFA and address several of our concerns regarding the use of these data as a valid measure of overall hospital quality.

The Medicare mortality data provided by HCFA includes all Medicare patients who died within thirty days of admission at Mercy Hospital. This includes Medicare patients who died after discharge from the hospital. Additionally, only the last inpatient admission of Medicare patients is included in the total number of cases reviewed.

The 1986 HCFA data provided Mercy Hospital indicates that 2,519 Medicare patients were considered in the statistical model. According to our records, 3,792 Medicare patients were admitted to Mercy Hospital in 1986. This large difference is presumably attributable to HCFA's count of only the last inpatient admission of Medicare patients. The HCFA data also indicates that 282 Medicare patients died within thirty days of inpatient admission to the hospital. Of these, 210 Medicare patients died within the hospital, while 72 died after discharge. Of those 72 patients, it is impossible to verify the percentage of those who were in fact alive as information concerning death after discharge is not included in the patients' medical records.

In one of the seventeen diagnostic categories used by HCFA to group admission diagnoses, HCFA's computed Medicare mortality rate for Mercy Hospital falls outside the range of the predicted mortality range. Several factors may account for this difference. This category, low-risk heart disease, includes patients who are admitted with many types of heart disease, previous myocardial infarctions, and hypertension. Our records indicate that of the 21 Medicare patients who died within this category, 13 were inpatients, 5 were at home, 2 were in skilled nursing facilities, and 1 was in an elderly residential facility.

Mercy Hospital • 701 10th Street S.E. • Cedar Rapids, Iowa 52403 • (319) 398-6011

In this category, the average age of the Medicare patients who died was 75.7 years old. Many of these patients had secondary diagnoses or predisposing factors which would make the chance of death more likely than patients without these complicating factors. Some of these complications and comorbid conditions include: end-stage chronic obstructive pulmonary disease, previous myocardial infarctions, end-stage renal disease, out-of-hospital cardiac arrest, severe aortic stenosis, and severe hypertension. For some of the patients with these complicating conditions, death was expected or a significant possibility at admission as indicated by the six "end-stage" secondary diagnoses. Therefore, a "higher than predicted" mortality rate for this category is a strong possibility.

The HCFA data supplied to Mercy Hospital will be used in conjunction with other data by the hospital's quality assurance program to continue review of all hospital deaths. Currently, the quality assurance program reviews all deaths within the hospital for any unusual occurrences or events.

Thank you for the opportunity to comment on this HCFA data.

Sincerely,

A. James Tinker
Administrator

lls

MERCY HOSPITAL

West Central Park at Marquette • Davenport, Iowa 52804 • 319-383-1000

Medicare Provider
#160033

October 21, 1987

Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Gentlemen:

We have reviewed your data submitted to our attention by your letter dated September 21, 1987. Our comments follow.

First, we do want to acknowledge that of those cases which expired in-house, our figures are essentially identical. However, there is a significant difference in the total number of cases. Our computation (attached) shows 2,639 cases while your data shows 1,996 cases. When the corresponding percentages are calculated, with the correct number of total cases in each category and overall, our percentages are found to be in the lower range of mortality rates.

Secondly, and as a final comment, it is interesting to note that HCFA originally said that DRG's would place patients in homogeneous groups. In this data, only one category (sepsis) was based on DRG.

Sincerely,

MERCY HOSPITAL
Provider #160033
Davenport, Iowa 52804

DEATHS - 1986

MERCY HOSPITAL
Davenport, Iowa

Provider #160033

		MERCY DATA			BCFA DATA				
	Category	Cases	Deaths	%	Cases	Deaths in house	Deaths after discharge	Deaths Total	%
CA	Cancer	217	39	18	142	35	8	43	30
CE	Cerebrovascular Accidents	100	21	21	59	19	4	23	39
EY	Opthalmologic Disease	36	0	0	27	0	0	0	0
GC	Gastrointestinal Catastrophes	58	9	16	39	8	0	8	21
GI	Gastrointestinal Disease	253	10	4	188	12	2	14	7
GU	Urologic Disease	79	2	3	58	1	2	3	5
GY	Gynecologic Disease	8	0	0	6	0	0	0	0
HL	Low-Risk Heart Disease	206	6	3	109	6	2	8	6
HM	Severe Chronic Heart Disease	126	22	18	72	20	3	23	32
HS	Severe Acute Heart Disease	55	17	31	48	17	1	18	38
ME	Metabolic/Electrolyte Disturbances	77	3	4	48	2	5	7	15
OP	Orthopedic Disorders	289	2	0	214	1	0	1	0
PN	Pulmonary Disease	250	33	13	154	35	5	40	26
RN	Renal Disease	15	3	20	12	3	0	3	25
SE	Sepsis	24	7	29	17	7	0	7	41
TR	Severe Trauma	77	8	10	63	8	3	11	17
	SUBTOTAL	1870	182		1256	174	35	209	
UN	ALL OTHER CASES	769	26	3	740	34	16	50	7
	TOTAL	2639	208	8	1996	208	51	259	13

IA 93.1

MERCY HOSPITAL MEDICAL CENTER

October 23, 1987

Medicare Provider No. 16-00-83

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

The mortality rates of Medicare patients at Mercy Hospital Medical Center fall well within the accepted predicted mortality ranges, according to your latest study. However, we wish to take this opportunity to comment on our mortality rate for severe chronic heart disease, as reflected in your study, the time-frame used for selecting mortality figures, and the time allowed for review of this study.

Unique Services Appearing to Result in Higher than Average Mortality

According to your figures, Mercy Hospital Medical Center had a mortality rate of 27 percent in the area of Severe Chronic Heart Disease (which includes rheumatic heart failure (congestive); hypertensive heart disease with congestive cardiomyopathies; congestive heart failure; and acute edema of lung, unspecified). The range of predicted mortality rates in this category is 17 to 29 percent. We feel it is important to address this category, because - while our rates are clearly acceptable - it appears that we are at the high end of that range. This may be confusing to some observers since under your statistical calculation where a hospital falls in the range of predicted mortality rates is not significant.

Further, as you are well aware, Medicare patients are either already disabled or aged, and they are at much higher risk than the general census as a whole. Because of the age and frequent infirmity of many Medicare patients, they are much more susceptible to the items cited in this category. It is important that your interpretive remarks accompanying the release of the mortality information stress that these patients are at higher risk than the general population, thus the mortality rate is expected to be higher for them than it would be for the general public.

We are so concerned about the veracity of your extrapulations and the implications that they will have that we re-emphasize the need for explicit caveats concerning the limitations of this data when the information is released in December.

SIXTH & UNIVERSITY / DES MOINES, IOWA 50314 / 515-247-3121

Mercy Hospital is a regional center of heart care, and patients from throughout the state of Iowa and neighboring states are transferred to Mercy for cardiac care. This is especially true of the high-risk patient and the near-terminal patient brought to Mercy for care. Many of these heart patients who enter the doors of Mercy Hospital are close to death at the time of admission. (A review of the figures indicates that a high number of those patients actually die in the first or second day of care. Without life support systems now available to paramedics, many of these patients would have been declared dead before ever arriving on our premises). This is especially true of the diagnoses in this category. The cure for cardiomyopathy is a heart transplant. And while transplants are performed at Mercy, there are not enough donor hearts available to transplant all cardiomyopathy patients, even those who fit all the other requirements for transplantation. Congestive heart failure can be controlled, but there is no cure, so it is a chronic, debillitating condition that can lead to death.

The Des Moines area is limited in the available number of skilled nursing care beds. Therefore, many patients with chronic cardiac degenerative conditions who could be transferred from the hospital to a skilled care bed are forced to stay in the hospital because there is no place else for them to go. Conversely, we receive patients with chronic cardiac degenerative conditions who might more suitably be served in skilled care beds if they were available.

Data Verification

The 30 days allowed for review of our 4,811 cases is inadequate. As you know, to review the charts of all of these patients, after we have once established that they have in fact died, is a monumental task. While our spot check of medical records indicates few inaccuracies, we are troubled by the lingering doubt that there may be errors that we have yet been unable to locate.

It would be helpful to hospitals if the secondary diagnoses were indicated on the material provided, and it would also be helpful if secondary procedures would be indicated by code number. If this is not possible, at least the total number of diagnoses and procedures for each case would be beneficial. Also, using DRG code numbers would be more in keeping with the record keeping of most hospitals.

We also question the selection of 30 days as the arbitrary cutoff date for inclusion of patients in the mortality rate figures. We feel a definite need for a different methodology that examines deaths that have a direct correlation to the admitting diagnosis. For instance, a person who dies on the 31st day following the admitting diagnosis would not be counted in your mortality figures. But persons discharged from the hospital and later struck by a car

and killed within 30 days of admission would, as we understand it, be counted in the hospital's mortality figures. The use of an arbitrary cutoff date methodology is objectionable and should be changed.

We commend your efforts at producing meaningful statistics that can be used by the American health consumer. We recognize that you are aware of the shortcomings in the present system. We hope your pledge to continue to refine these statistics so they can be more meaningful in the future will be met.

Sincerely,

J. Patrick Logue
Corporate Vice President

JPL:ds

CLARINDA MUNICIPAL HOSPITAL

17TH AND WELLS STREETS
P.O. Box 217
CLARINDA, IOWA 51632-0217

IOWA HOSPITAL LICENSE #146

PHONE (712) 542-2176

"The Heart Beat Of The Community"

October 26, 1987

Director, Hospital Mortality Information
Health Standards and Quality Bureau
Health Care Financing Administration

Dear Director:

These comments are in response to the selected mortality information received from HCFA in September, which pertains to our facility.

While HCFA's stated "actual mortality rate" for our hospital was below the range of "predicted mortality rates" over-all and for each diagnostic category within the survey, I feel it is important to make comments relative to data presented for the cancer diagnostic category.

In our community, it is normal for cancer patients to remain at home and be treated by family members for as long as is possible. When the type of care becomes too demanding or exceeds the capability of family members, the patient is hospitalized. In a significant number of cases, the patient, family, physicians, and hospital staff understands the patient's condition to be terminal with death not an unlikely possibility.

This is borne out in a review of medical records for the patients noted by HCFA to have died with a diagnosis of cancer. In all, there were 9 deaths attributed to diagnosis involving cancer. 6 of 9 of these patients were expected to die with this hospitalization. A 7th patient died in a nursing home following discharge, with a discharge note that the patient's prognosis was poor. Another patient had refused attempts to diagnose and treat the expected diagnosis of cancer, a diagnosis confirmed by autopsy. A 9th patient had been admitted acutely ill. The attending physician felt the patient's religion may have kept the patient from seeking medical assistance until it was too late.

In sum, we feel this more than adequately explains that the deaths of these patients were usually expected due to terminal status, or are related to factors other than quality.

We have not devoted time to the review of patient cases in other diagnostics categories noted in your release. However, we are confident that had we done so, a satisfactory explanation, unrelated to quality concerns, would have resulted.

Sincerely,

Richard C Hamilton

Richard C. Hamilton
Administrator

RESPONSE TO HCFA:

In response to the Mortality Report for North Iowa Medical Center, the following points are made:

A. The data assumes that each hospital patient is "average" except with respect to the few characteristics included in HCFA's model.
In reviewing the cases listed in the categories, it is noted that the list of complications are not all inclusive. The model used by HCFA does not reflect the severity of the illness. In the cases reviewed, the average age was 80 years old with complicating factors, such as, renal failure, pneumonia, diabetes, hypertension, CHF, COPD, cardiovascular disease, and cardiac arrhythmias.

B. The smaller the number of admissions, the less reliable are the statistics.
In one category there was a total of four cases, two of which expired, which results in a higher mortality rate. In review of these cases, the severity of complicating conditions greatly impacted the outcome.

C. Basing the assessment of a hospital's performance solely on deaths, is a misleading casual relationship. Factors not considered with the HCFA model include patient factors such as personal health habits, the availability of supportive services in their community, and the care provided to the person prior to hospitalization. These are variables that can certainly impact the outcome.
The data is only measuring the relationship between the mortality risk and selected patient characteristics (i.e., age, sex, prior hospitalizations, transfer status, and underlying chronic conditions). With regard to hospital performance, it can serve as no more than a screening tool for use in clinical and management review. Mortality review has been an ongoing internal review for sometime at North Iowa Medical Center and will continue to be as it demonstrates our committment to quality care.

D. Of the cases reviewed, 30% of the patients arrived in the Emergency Room with resusitative procedures already implemented. 65% of the cases were known to be of grave prognosis or terminal condition upon admission. 25% of the cases were transferred from a Nursing Home or another hospital. It is also noted, that 86 of the cases were in the Cancer category. It is noted, that the North Iowa Medical Center complex and physicians treat numerous cancer patients, which again supports why the variable of community demographics is important.

E. It is also noted that the Case Mix Index for North Iowa Medical Center Medicare population is 1.2 which indicates the significance of this variable.

F. It is important for the consumers to be knowledgeable on the interpretation of this data. We are aware that various other agencies, such as the AHA and JCAH are continuing to investigate methods to evaluate quality.

G. This information will be used by the hospital and medical staff at North Iowa Medical Center to continuously evaluate the quality of care provided.

October 26, 1987

Jim Armstrong, Assistant Administrator

Cindy Baltes, Director of Quality Assurance

Osceola Community Hospital
NINTH AVENUE NORTH SIBLEY, IOWA 51249
PHONE 712-754-2574

Osceola Community Health Services
110 CEDAR LANE SIBLEY, IOWA 51249
PHONE 712-754-4611

October 19, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Admin.
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

In reviewing the mortality rates for the Osceola Community Hospital, I noted that the following two patients with patient I.D. number [redacted] and [redacted] were transferred from our hospital to another acute hospital, but the death is being charged against our hospital. I also question whether this death is also being charged against the hospital to which the patient was transferred, thereby counting this figure twice.

I strongly disagree with your department's contention that the mortality rates are a quality assurance measure of acute care hospitals. This is an erroneous assumption. The only way that the mortality rate can be utilized is to obtain additional information in regard to each of the patient's general health status, the stage of the patient's illness, the patient's psychological condition, and family support. I strongly oppose the publishing of these figures which are very misleading and which the public does not understand and use effectively.

I appreciate the opportunity to review the statistics prior to their being publicized by your department and for the opportunity to comment on your tabulations.

Sincerely Yours,

Frederick W. Haack
Administrator

lr/FWH

PALMER
MEMORIAL
HOSPITAL

112 JEFFERSON ST. WEST UNION, IOWA 52175

PHONE 422 3811

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201

Subject: Comments on HCFA Mortality Data
Medicare Provider Number: 601294

Dear Dr. Roper:

The review of mortality data at Palmer Memorial Hospital finds us in the acceptable range.

Our hospital is a small, rural, self-supported city hospital which has a hospice unit and accepts terminally ill patients from tertiary care centers. These patients prefer to die in a warm, comfortable environment closer to family and friends. There is a quality factor involved in the death process also. They have not been in their treatment hospital in the past thirty days so don't show in those statistics.

We at Palmer have allowed the living will to be used as a moral mandate from the patient to the hospital even before the Iowa law recognized them to be legally binding. As you know when a living will is part of the patient's chart he/she ethically mandates the physician not to use heroic measures to prolong life, but to allow death to occur in a dignified manner.

Our nursing staff is 92% Advanced Cardiac Life Support, (ACLS) certified (a percentage unattainable in many hospitals) and all nurses working in the emergency department are advanced trauma trained. With the physician and nursing staff working cooperatively at a high level of expertise and knowledge, we have been able to balance out our hospice/living will admissions to the hospital. Perhaps next year more patients will choose to be closer to home in their last days of life and we may not be in the "acceptable" range, never the less, we will continue to accept these patients and try to meet their needs and their family's needs.

We will continue to maintain and improve the quality of care at Palmer knowing that statistics aren't always able to reflect the qualitative factors involved in providing personalized care.

Sincerely,

Jeanine Matt

Jeanine Matt, Administrator
Palmer Memorial Hospital

ST. ANTHONY REGIONAL HOSPITAL & NURSING HOME

SOUTH CLARK STREET • CARROLL, IOWA 51401 • 712-792-3581

People Caring for People . . .

October 9, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

I am writing to comment on the hospital mortality information which the Health Care Financing Administration plans to publish in December 1987. I feel that the information that you are about to publish is not very useful and in some cases statistically insignificant.

After having reviewed the information I find that you will be attributing mortality rates of 33% to St. Anthony Regional Hospital based upon one death out of a total of three cases that have been treated. Similarly other categories of the data have very small numbers with which to work, and therefore, lead to questionable percentage rates for mortality.

St. Anthony Regional Hospital is an acute care facility with an attached long term care facility. In addition, there are two other long term care facilities located within the community. For this reason, St. Anthony Regional Hospital treats an above average number of elderly patients.

In your data, you are attributing a total of 50 deaths to St. Anthony Regional Hospital for the time frame of 1986. However, 26% of these deaths did not occur within St. Anthony Regional Hospital, but occurred at other facilities or at private residents subsequent to discharge from the hospital.

Given the above limitations and others that are present in this information, I do not feel that it will be beneficial for you to publish this information and I would encourage you to develop someother standards by which to measure quality of care in acute care hospitals.

Sincerely,

Gordon A. Larson
Assistant Administrator

GAL/lr

ST. JOSEPH
MERCY HOSPITAL

1410 NORTH FOURTH STREET • CLINTON, IOWA 52732 • PHONE (319) 243-5900

October 27, 1987

Health Care Financing Administration
200 Independence Avenue South West
Washington, District of Columbia 20201

Dear Sirs:

We have reviewed the mortality information submitted to us by HCFA, and wish to comment on it. We will divide our comments into three categories: Accuracy, Validity, and Usefulness.

In our review of our own data there were two decrepancies noted on the report relating to the date of death. In both cases our records indicate that the date of death was the same as the date of discharge. However, the report lists one as three days after the date of discharge, and in the other case the date of death is listed on the report as the date prior to discharge. We also noted two patients who were categorized in low risk diagnostic categories, when the patients had actually experienced acute myocardial infarction. Both of these cases were billed correctly. These errors in the accuracy of the study do not materially affect the outcome of the study.

In our review of the data we found that in several cases the diagnostic category, though accurate, did not reflect that the patient was suffering from an underlying terminal disease. Three such examples are as follows:

Patient X had a principal diagnosis of vomiting. This patient was suffering from malignant Zollinger-Ellison syndrome at the time of admission and the physician noted on the history and physical that she is "just wasting away quite slowly". The patient died the day after admission.

Patient Y entered the hospital with atrial fibrillation but was also suffering from complete esophageal obstruction secondary to cancer. The physician stated on the history and physical that "All measures will be palliative at this point and the patient and his family understand this". The patient was tansferred back to a nursing home for terminal care. The physician stated at the time of discharge the prognosis was very poor. The patient died sixteen days after discharge from the hospital.

Patient Z was admitted with principal diagnosis of chronic anemia. This patient also suffered from pancreatic carcinoma with the following complications: pancreatic insufficiency, progressive weakness. On history and physical, the physician states that the patient is in a terminal situation. Prognosis at the time of discharge was very poor. The patient died nine days after discharge.

As can be seen from the above cases the admission diagnosis is not always reflective of a terminal condition of a patient.

The third comment relates to the uses and usefulness of the information. Although for our hospital our mortality rates are within the range of pricted mortality rates in all cases, we are concerned about the potential uses of the information. A single statistical measure such as mortality rates does not necessarily indicate quality or lack of quality at a particular hospital. The hospital maintains a complete qaulity monitoring system which includes a review of all inpatient mortality as one of its criteria. Additionally, percentages can be skewed by a low number of cases. On our hospital's own incidents, the number of cases in a disease category was less than ten in three of the disease categories. To compare the mortality at one hospital to another hospital without having any more information on the data would be misleading at best.

Sincerely,

Ronald R. Reed

Ron R. Reed
President and Chief Executive Officer

ST. JOSEPH MERCY HOSPITAL

84 BEAUMONT DRIVE • MASON CITY, IOWA 50401 • PHONE (515) 424-7211

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

RE: Mortality Information Report for Medicare Patients 1986; St. Joseph Mercy Hospital Response (Medicare Provider #1600643)

Thank you for allowing St. Joseph Mercy Hospital to review the mortality data in advance of the December publish date and for the opportunity to provide our comments. We believe the mortality information can be used as a screening instrument for additional case review. The data is fairly accurate but not a total indicator of quality health care. Because the report focused on patients who had died within thirty days of a hospital admission, many patients were discharged in stable condition from St. Joseph Mercy Hospital to other health care facilities where they died.

The mortality report indicates that in all diagnostic categories the actual mortality rate at St. Joseph Mercy Hospital is within the HCFA predicted range of mortality rates. We are pleased with this finding and believe that the report shows that St. Joseph Mercy Hospital treats enough patients annually so that a statistical aberration did not occur in any diagnostic category. For 1986, St. Joseph Mercy Hospital compares statistically well with other hospitals in the United States.

The severe trauma diagnostic category was analyzed further because we do not believe that trauma deaths occurred in the percentage noted. Our analysis revealed that there were a total of twelve trauma deaths; five of these patients died outside of the hospital. In this subset, one patient died after being transferred to a tertiary care center, three patients died in nursing homes and one patient died at home. The remaining seven patients died in the hospital; none of the patients died before receiving adequate treatment of their injuries or while in the hospital's trauma center. The average length of stay for these patients was 5.1 days. The median age for the twelve patients

who died was 86.5 years. A chart review demonstrated the presence of multiple major medical conditions such as end stage heart, renal, and liver disease, cardiovascular disease and cancer. When coupled with the traumatic injuries (ten patients were admitted with hip fractures and two with severe head injuries), these complicating conditions undoubtedly contributed to the cause of death. All twelve deaths were categorized as trauma deaths because the HCFA categorization is based on admitting diagnosis instead of actual cause of death.

Additionally, none of these cases were identified by the professional review organization, the Iowa Foundation for Medical Care, for an admission, a quality of care, or an inappropriate discharge concern. All in-hospital deaths are routinely reviewed as one part of St. Joseph Mercy Hospital's comprehensive ongoing quality management program.

We appreciate the opportunity to respond to this mortality report and hope that our comments are beneficial for future reports.

Sincerely,

John B. Morgan

John B. Morgan
Vice President

JBM/pc

cc: David Vellinga, President
David Little, M.D., President, Medical Staff
Sam Porter, M.D., Vice President, Medical Affairs

St. Joseph's Mercy Hospital
Centerville, Iowa 52544

Medicare Provider #1600205

These comments are in response to the mortality data prepared by HCFA in regard to St. Joseph's Mercy Hospital in Centerville, Iowa.

The data used by HCFA indicate that a total of 69 Medicare patients admitted to St. Joseph's Mercy Hospital died within 30 days of admission. Our own records indicate that 59 died while in the hospital and 10 died after discharge. Our records also indicate that 17 of those 69 patients had comments in their charts by their physicians indicating that the cause of their admission to the hospital was also likely to be the cause of their death in the near future.

We are pleased to see that in no categories did our actual mortality rate exceed the predicated mortality rates as calculated by HCFA. However, without knowing the precise means used by HCFA to do their calculations, and recognizing that death serves in no way to indicate anything about the quality of care received by an individual, we are unwilling to accept these findings as anything more than computer generated statistics with no direct correlation to care delivered in our hospital.

Kenneth L. Smithmier
President/CEO

ST. LUKE'S
HOSPITAL

1026 A AVENUE N E
CEDAR RAPIDS IOWA 52402
(319) 369-7211

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dr. William L. Roper:

St. Luke's Hospital, Medicare #16-0045, has reviewed the mortality data.

St. Luke's Hospital and medical staff maintain a comprehensive Quality Assurance Program which monitors and evaluates the quality of patient care on an on-going basis and assures that care is provided in a safe environment.

As a regional medical center providing full range of services with the exception of burn and transplant services, we believe the data supports the quality of care provided by the medical and hospital staff.

Sincerely,

Samuel T Wallace

Samuel T. Wallace
President

st

ST. LUKE'S
Regional Medical Center

2720 STONE PARK BLVD. • SIOUX CITY, IOWA 51104 • PH. (712) 279-3500

October 22, 1987

William L. Roper, M.D, Administrator
Health Care Financing Administration
Dept. of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

This letter contains comments on Mortality Data for Medicare patients treated at St. Luke's Regional Medical Center in Sioux City, Iowa (Medicare Identification Number 160146). The comments are intended to assist individuals reviewing Mortality Data and are separated into three categories: specific comments on St. Luke's data, general comments for those reviewing data from any hospital and comments meant for HCFA officials.

SPECIFIC COMMENTS

St. Luke's Regional Medical Center is committed to providing high quality care for all patients seeking services at the Medical Center. Continuous monitoring of care quality is a high priority undertaking for members of the Medical Staff, hospital employees and Board of Directors. Comprehensive care quality review includes assessing many factors; one of which is mortality data.

The Actual Mortality Rate identified for St. Luke's Regional Medical Center was 10%. This is the death rate for Medicare patients only. The overall Mortality Rate at St. Luke's Regional Medical Center is 3% when patients of all ages are considered. Statistically, the chances of dying increase with age and since Medicare patients are generally older, it is reasonable to expect the number of deaths in the Medicare patient group would be greater.

At St. Luke's Regional Medical Center, the mortality rate for only one Diagnostic Category lies outside the Range of Predicted Mortality Rates. This category is entitled "Gastrointestinal Catastrophies". Physicians at St. Luke's Regional Medical Center treat an extremely large number of patients with gastrointestinal diseases. It is reasonable to expect that a certain number of the patients seeking treatment for gastrointestinal diseases at St. Luke's Regional Medical Center would be severely ill and therefore more likely to die from these diseases. It is therefore expected that St. Luke's Regional Medical Center's actual Mortality Rate for Gastrointestinal Catastrophies falls outside the predicted range.

St. Luke's Regional Medical Center is a regional referral center. The Medical Center accepts for treatment many severely ill patients requiring specialized care not available in other hospitals.

Our initial review indicates data input errors for the date of death on four patients. These are:

Patient ID No.	Recorded Death Date	Actual Death Date
[redacted]	03/09/86	03/08/86
	05/20/86	05/19/86
	11/10/86	11/09/86
	10/18/86	10/17/86

These corrections are important to indicate the patients died in the acute care setting rather than following their discharge from the Medical Center.

GENERAL COMMENTS

Members of the general public who wish to review and understand Mortality Data must bear certain facts in mind. It is vital to understand how the Federal Government derived the Mortality Data and its significance when considering the quality of care provided at hospitals in the United States. These facts include:

- The Mortality Data is only for Medicare patients. Most of these patients are elderly, and many have long-term serious illnesses.

- The Mortality Data includes some patients who died after their discharge from a hospital. Hospitals cannot control care provided following a patient's discharge. Some of these patients may have died from accidents or problems not related to their hospital stay.

- The Federal Government data analysis method fails to take into account how severely ill patients were and other medical problems the patients might have at the same time.

- The Government's Data Analysis does not take into account the actual cause of death.

- Analysis of deaths indicates little regarding the quality of care provided by hospitals. Such analyses may show potential areas needing further evaluation.

- True quality of care review can only be performed by knowledgeable, impartial individuals who conduct detailed review of the patient's medical record.

- 1985 and 1986 Mortality Data released by the Federal Government cannot be compared. 1985 Data included all Medicare patients who died while hospitalized. 1986 Data includes any Medicare patient who died within thirty (30) days after admission to a hospital. The 1986 Data therefore includes some patients who died following their release from a hospital and excludes patients who died in a hospital but stayed an extremely long time.

- The Federal Government's data model fails to consider the wide range of factors with a significant impact on mortality. The Government did not validate the data model through adequate testing.

- The Federal Government acknowledges that mortality statistics are a "complicated and controversial undertaking" (August 17, 1987 Federal Register; 852: 30741-30745) and notes the "system needs to be refined to better reflect severity of illness and the size of the hospital".

COMMENTS FOR HCFA CONSIDERATION

The following comments are intended for Health Care Financing Administration consideration. We urge the Health Care Financing Administration to:

- Consistently utilize DRGs to portray mortality data rather than HCFA defined categories based on unique aggregations of ICD-9-CM codes.
- Provide social security information used by HCFA in order that hospitals can verify the accuracy of HCFA released data.
- Continue to refine analysis methodologies and data portrayal formats.
- Provide usable demographic information. Large hospitals are severely hampered when only six letters of a patient's last name are provided. HCFA would render hospitals a significant service by using hospital-assigned medical record numbers as well as Medicare numbers, by utilizing birth dates rather than ages, and by providing patient disposition information gathered from UB-82 forms.

Thank you for this opportunity to provide comments. I expect the preceding comments will accompany Mortality Data released for St. Luke's Regional Medical Center.

Sincerely,

David O. Biorn
President

DOB/tln

Celebrating 25 Years Of

A Tradition Of Excellence

With A Personal Touch

STEWART MEMORIAL COMMUNITY HOSPITAL

1200 WEST MONROE • LAKE CITY, IOWA 51449 • TELEPHONE 712-464-3171 • 800-262-2614

October 16, 1987

Dr. William L. Roper, M.D.
Administrator
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper,

I have reviewed your letter of September 21, 1987 regarding information on mortality in short term acute care hospitals.

I would challenge the statistical validity of the tables. I question how a predicted range can be of any value when a sample is not of acceptable size statistically.

There are four issues or concerns of mine regarding the information I have received.

1.) What is the validity of Ranges as broad as 0-100% or 5%-94%?

2.) What is a valid sample size? I would suggest a size of two is not large enough.

3.) Is there anything unique to the cases that are considered low risk that should be discussed in the article?

4.) What is the average lengths of life in the United States? In this study the average age for Stewart Memorial Community Hospital was 82 years. Would age possibly make a low risk diagnosis somewhat a high risk?

I would suggest the study with small sample sizes has very little to offer the public. There are enough ambiguities in the current samples to indicate the study would not and does not fair well under close statistical analysis.

I see no value in releasing this information in it's current status and would urge that it not be released.

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JCAH Accredited

Thank you for the opportunity to respond in advance of the release. If you have any questions, please contact me.

Sincerely,

John Comstock
Associate Administrator

JC:rs

cc: Dan Drees;IHA

Story City Memorial Hospital

Story City, Iowa 50248

October 16, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O.Box 26684
Baltimore, Maryland 21207

RE: Hospital Mortality Study - 1986
Medicare Provider #1601237

To Whom It May Conern:

Pursuant to your letter dated, September 21, 1987, we are enclosing the mortality information that you requested with our additional comments for your file and use. Please refer to the enclosed and make the required corrections.

If we can be of any further assistance, please feel free to contact us.

Sincerely yours,

Steven Carter
Administrator
Story City Memorial Hospital

SC/ss
Enclosures

The hospital's comments also include its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

STORY COUNTY HOSPITAL

630 SIXTH STREET
NEVADA, IOWA 50201
515-382-2111

October 6, 1987

Provider #16-0088

In response to your mortality information about Medicare patients treated at the Story County Hospital during 1986, the following comments are offered:

1. The hospital exceeds the range of predicted mortality rates for one diagnostic category (sepsis); however, the 100% actual mortality rate has no significance considering the hospital had only one case.

2. The actual mortality rates are of little value to the public or to other end users because they do not have sufficient information to judge the significance of the data; for example, Story County had 29 Medicare deaths during 1986. The average age for these cases was 84.34 years of age. The range was 64 to 94 years of age. Eighteen of 29 deaths were persons above 85 years of age. Hospitals that provide care to very elderly Medicare beneficiaries are going to have a higher than average mortality rate.

JJKaduce

John J. Kaduce
Administrator
Story County Hospital

The University of Iowa
Iowa City, Iowa 52242

The University of Iowa Hospitals and Clinics
Office of the Director and Assistant to
The President for Statewide Health Services

(319) 356-1816

1847

October 20, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Predicted Mortality Rates for The University of Iowa Hospitals and Clinics
Provider #16-0058

Dear Dr. Roper:

We are very appreciative of the opportunity to provide comments on the University of Iowa Hospitals and Clinics' (UIHC) mortality rates prior to their public release in December, 1987.

While we are gratified that our actual mortality rates fall well within or below the predicted mortality ranges, especially since we are likely to care for the most severely ill patients, we do not subscribe to the general methodology used and offer a number of considerations for your review as you develop more valid methods of reporting national mortality/quality data in the future.

1. Comprehensive tertiary care referral centers such as the University Hospitals treat more severely ill patients who often have a poorer prognosis at admission and receive specialized services not otherwise available in community hospitals. Therefore, the University Hospitals' experience cannot be validly contrasted with community hospitals which can be expected to have lower mortality rates based on the differences in patients each respectively serves. In fact, many programs, by design, bring those patients with the highest potential for death to our center for care to assure that they have every possible advantage for survival.

2. Only a limited number of variables were used in the model. Deaths may be attributable to many other variables, most notably the severity of the patient's illness, which were not incorporated into HCFA's methodology except for the consideration of a limited group of comorbidities. Mortality rates are, at best, a crude measure of quality. Staff at the University Hospitals routinely review all in-hospital deaths as well as a broad array of other clinical outcome measures as an integral component of its comprehensive Quality Assurance Program.

3. Deaths following discharge, attributed to the hospital using HCFA's 30 days after admission criterion, may be unrelated to the condition of the patient. To ensure more appropriate attribution, severity of illness at discharge should be considered as a future refinement to the HCFA methodology.

4. The validity of the model has not been tested or reported. HCFA should test and report the model's sensitivity, specificity, and positive and negative predictive values and then apply the model to a new population (or sample) to determine the model's validity when applied to this new population group. One approach would have been to split the 6.5 million records into two groups and develop a model based on one of the groups and then apply the model to the second group, thereby measuring its validity.

5. Significance tests were applied to each of the diagnostic categories and, although The University of Iowa Hospitals and Clinics was not above the predicted range in any category, a hospital may expect to be outside of the range five times out of a hundred, by chance alone, when using a 95% confidence interval.

6. Finally, although we identified no systematic discrepancies in the HCFA data, several potential errors were uncovered, including:

   a. One patient cannot be located in our data base - [redacted], 10/7/86 - 10/8/86 admit/death.
   b. One patient was classified as dead prior to actual date of discharge. Patient #[redacted], [redacted]r - date of death listed as 11/12/86 -- patient actually discharged on 11/18/86, with a subsequent readmission on 12/16/86. According to our records, this patient is most definitely alive, with her most recent visit to the University Hospitals in September, 1987.
   c. One patient has an inaccurate date of death. Patient #[redacted], [redacted] 2/9/86 - 2/10/86. Date of death listed as 2/28/86 - actual date of death verified with Clerk of Court is 2/10/86.
   d. The following patients were listed in our data base as being in a different diagnostic category than reported by HCFA: [redacted], and [redacted].
   e. UIHC's data indicate 4,656 Medicare patients were served in calendar 1986 (with additional admissions removed), contrasted to HCFA's reported total of 3,700. This increases the denominator in many diagnostic categories and results in lower actual death rates than those reported. As an example, HCFA's reported aggregate death rate for University Hospitals is 8%, while our data indicate that our death rate is actually 6.4%.

We realize the public is interested in obtaining objective indicators of quality with which to differentiate among providers. This mortality data release is a first step towards this end. However, we urge caution in the widespread use of this mortality data as a valid benchmark of quality, given the array of considerations we have presented in this correspondence. We look forward to working with the Health Care Financing Administration as the methodology is further refined.

Sincerely,

Amy B. O'Deen
Assistant Director

Gary S. Levitz
Assistant to the Director

VAN BUREN COUNTY MEMORIAL HOSPITAL

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October 23, 1987

William L. Roper, M.D.
HCFA Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

In reviewing the information received in our facility 9-30-87 regarding mortality information a review of the specific cases listed reveals the following:

1) 1 patient is listed as a low risk category GI disease. The patient was admitted for cholecystectomy due to chronic recurrent gallbladder disease; developed perforated ulcer 6 days following initial surgery which required a second major surgery in this 84 year old patient. The patient expired following the second surgery. I believe to show this as a death in a low risk category is misleading.

2) I have a question as to why a diagnosis of acute respiratory failure/ arrest is not considered high risk in Medicare aged patients. 6 of the cases listed as "UN" fall in this category. All 6 expired less than 24 hours following admission. 1 case is shown as discharged 4-7 and expired 4-8. This was a 92 year old, discharged from acute to ICF care in this same facility and expired in this facility.

3) Only 1 patient fell into the renal disease category. This skews the statistics by showing a 100% mortality rate in this category.

4) Because we are a swing bed facility and the reason for admission in many of these cases is rehabilitation/convalescence following other treatment, we have 4 cases of patients with V codes as principal diagnoses who expired. All 4 of these were patients with extensive metastatic Ca. While 1 case is shown to have been discharged 11-29 and expired 12-9, the patient actually expired in our holding area having had longstanding Ca. of the brain with seizures. It was the wish of the patient and his wife that he be cared for at home at times when seizures could be controlled

(Continued)

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

We honored these wishes.

In summary, I would offer a suggestion that some other means be developed for making information available to the public. HCFA requirements for sequencing diagnoses for billing do not lend themselves well to mortality reporting. Also, grouping swing bed patients with acute care patients in 1 report skews the information even further.

With all the record review presently conducted by the PROs and so much of the health care dollar going for other than patient care, surely there is sufficient monitoring and reporting taking place to ensure quality without this sort of reporting. What useful purpose does this report serve?

Sincerely,

Rita Hughes, ART

Rita Hughes, ART
Director of Medical Records

reh

pc: Ron Volk, Administrator
Each Medical Staff Member
Art Spies, Iowa Hospital Association
Rita Smith, QA Coordinator
Sue Pankey, Director of Nursing

HOSPITAL = 160054 VAN BUREN CO MEM HOSP KEOSAUQUA IA

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	186	17 %	9 TO 21 %
CA - CANCER	6	67 %	9 TO 75 %
CE - CEREBROVASCULAR ACCIDENTS	1	0 %	0 TO 97 %
EY - OPHTHALMOLOGIC DISEASE	1	0 %	0 TO 100 %
GC - GASTROINTESTINAL CATASTROPHES	2	0 %	0 TO 93 %
GI - GASTROINTESTINAL DISEASE	13	8 %	2 TO 41 %
GU - UROLOGIC DISEASE	2	0 %	0 TO 100 %
HL - LOW-RISK HEART DISEASE	16	0 %	1 TO 34 %
HM - SEVERE CHRONIC HEART DISEASE	18	22 %	10 TO 49 %
HS - SEVERE ACUTE HEART DISEASE	8	50 %	16 TO 76 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	2	0 %	0 TO 90 %
OP - ORTHOPEDIC DISORDERS	4	0 %	0 TO 99 %
PN - PULMONARY DISEASE	15	33 %	7 TO 49 %
RN - RENAL DISEASE	1	100 %	0 TO 97 %
TR - SEVERE TRAUMA	2	50 %	0 TO 96 %

IA 134.2

VETERANS MEMORIAL HOSPITAL
Waukon, Iowa 52172
319 568-3411

October 1, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: Medicare Provider #160023

Gentlemen:

I believe that a mistake was made on the mortality information which you mailed to this hospital for our review.

On the list of individuals whose last admission in 1986 was supposed to be to our hospital and who died within 30 days of that admission, a copy of which is enclosed, there is an error.

[redacted], Patient ID#[redacted], was transferred from our hospital and admitted to LaCrosse Lutheran Hospital, LaCrosse, Wisconsin, before she died of severe acute heart disease. Her last admission, therefore, was not at Veterans Memorial Hospital, but rather was at LaCrosse Lutheran Hospital.

Please correct your data.

Thank you,

Kenneth Ewen

Kenneth Ewen
Administrator

KE:lm

Enclosure

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Washington County Hospital
400 East Polk St. P.O. Box 909
Washington, Iowa 52353
319-653-5481

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir,

On behalf of Washington County Hospital I feel that the following comments are appropriate regarding the recent study on mortality rates, that were compiled by your office, about the Medicare patients that had been treated by our hospital:

1. We are the only hospital in the county serving a high elderly population. Our county ranks fourth in the state in the number of elderly residing in the county. Our number of Medicare admissions is higher than all of the other admissions to our hospital. I question if we would be considered an average hospital, relative to patient mix.

2. We also provide intermedicate care in our long term care unit. This tends to insure admission to our acute facility should the need arise, for that level of care.

3. Some of the diagnostic categories, for our facility, had too small a sample to be meaningful.

4. Severity of illness has not been considered in the statistics.

5. Our Utilization Review Committee is reviewing all deaths on a monthly basis to determine if any quality issues were present.

Thank you for allowing enough time for us to comment on the data your office has presented.

Yours truly,

Gary W. Kluber

Gary W. Kluber
Administrator

GWK:cg

Waverly Municipal
Hospital
312 Ninth Street, Southwest
Waverly, Iowa 50677
(319) 352-4120

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

I have reviewed the mortality data and am relieved to find all are within the predicted ranges for the various categories. I would like to comment on the data by expressing the following concerns:

1. As a community having a large percentage of elderly people it would be appropriate to assume that mortality rates will be higher. The published ranges do not include age as a variable.

2. There is no allowance for a patient's care given elsewhere who subsequently returns to our community for terminal care.

3. Will this information make physicians and hospitals less caring for terminal patients because they will be encouraged to hold down the mortality rate?

Sincerely,

Arnold Flessner

Arnold Flessner
Administrator

AF:mm

WINNESHIEK COUNTY MEMORIAL HOSPITAL
DECORAH, IOWA 52101

319 - 382-2911

October 21, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, M.D. 21207

Dear Mr. Roper:

The staff of Winneshiek County Memorial Hospital has received and reviewed the HCFA mortality data for our hospital. We appreciate the opportunity to comment on those data prior to their final publication in December.

In verifying the data, we wish to note the following:

1. deaths of patients (occurring within 30 days of admission to this hospital) whose hospital care was initiated here but were subsequently transferred to more specialized care were counted (n=8) as well as patients whose acute care was received elsewhere and were transferred back here for skilled care (n=2; patient ID [redacted].

Besides the fact that, according to your methodology, these latter two patients should have been included with the hospital of origin (otherwise, are you double counting?), we question the validity of counting patients transferred out (or coming in). As a primary care hospital, Winneshiek County Memorial Hospital works closely with regional referral centers and transfers patients there when appropriate. This concept of regionalized care is, perhaps, not well appreciated by the HCFA data model. We feel a method which attributes deaths to the institution where care was initiated and overlooks the management of that care (e.g. referrals) is not refined enough, particularly in light of the public's perception of these data as a measure of quality of care.

2. mortality was coded by principal diagnosis. It appears from our review of the data that in numerous instances, the principal diagnosis was the immediate, not underlying, cause of death (or hospitalization). For example, in the seven deaths coded as renal disease, six of the patients had underlying conditions (e.g. cancer in two cases) causing the renal failure.

Conclusions based on these data give an erroneous impression of the true frequency and impact of the disease categories.

We realize that any type of quantitative analysis has its limitations. It is our hope that HCFA will consider these suggestions in future refinements of the hospital mortality reports.

Sincerely,

Paul J. Anderson
Administrator

Kansas

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																													
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease												
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent								
ALLEN CO HOSP IOLA KS 66749	KS-13	449	17	10-19	26	27	8-40	24	46	18-54	10	30	4-53	19	11	9-47	22	59	25-65	10	10	7-59	60	23	14-37								
ALLEN SUSAN & MEM HOSP EL DORADO KS 67042	KS-14	591	10	8-16	46	28	13-40	22	18	14-52	14	29	4-46	22	36	11-47	23	35	19-58	15	0	3-42	39	13	9-36								
ANDERSON CO HDSP GARNETT KS 66032	KS-15 *	191	12	9-21	9	44	8-64	10	20	9-61	3	0	0-83	13	38	10-56	7	29	10-71	8	0	4-60	31	3	8-37								
ARKANSAS CITY MEM HOSP ARKANSAS CITY KS 67005	KS-16	524	16	9-17	21	38	14-53	22	18	14-51	11	18	4-52	34	29	13-42	13	69	18-68	14	21	5-48	63	30	12-33								
ASBURY HOSP SALINA KS 67401	KS-17	1402	10	8-15	117	21	17-36	31	35	16-48	20	5	5-41	46	28	14-39	43	44	26-56	15	7	4-45	71	23	12-32								
ASHLAND DIST HDSP ASHLAND KS 67831	KS-18	32	13	5-31	1	0	0-99	1	0	1-97	1	0	0-97	3	67	1-81	.	.		2	0	0-90	6	17	4-66								
ATCHISON HOSP ATCHISON KS 66002	KS-19 *	480	14	10-18	37	27	10-39	11	73	13-64	12	17	6-52	47	23	13-38	14	50	19-67	13	8	7-52	53	9	10-33								
ATCHISON HOSP/LT ATCHISON KS 66002	KS-20 *	24	8	3-30	.	.		.	.		.	.		3	33	1-81	1	0	1-97	.	.		.	.									
ATTICA DIST HOSP 1 ATTICA KS 67009	KS-21 *	74	9	7-23	.	.		4	25	5-78	1	0	0-98	3	0	2-82	7	29	10-72	1	0	0-98	12	17	5-50								
AUGUSTA MEDICAL COMPLEX IN AUGUSTA KS 67010	KS-22	243	19	9-20	16	44	12-56	9	56	12-68	6	33	1-63	12	42	9-56	2	0	2-90	2	50	1-89	38	32	14-42								
AXTELL CHRISTIAN HOSP NEWTON KS 67114	KS-23	530	9	7-15	28	14	11-43	17	53	11-52	6	33	4-67	27	15	11-43	17	41	19-64	6	17	1-63	56	13	10-33								
BAXTER MEMORIAL HOSP BAXTER SPRINGS KS 66713	KS-24 *	161	18	11-24	7	57	4-63	7	43	8-69	4	0	4-77	13	8	6-50	17	41	22-67	12	0	4-49	16	25	8-50								
BEHAVIORAL MEDICINE CENTER PARSONS, KS 67357	KS-25	28	0	0-25	.	.		.	.		.	.		.	.		.	.		.	.		.	.									
BETHANY MEDICAL CTR KANSAS CITY KS 66102	KS-26	2190	15	9-16	143	27	18-36	77	39	18-39	51	14	8-32	104	24	14-31	88	44	28-50	79	28	11-33	125	22	13-29								
BETHEL DEACONESS HOSPITAL NEWTON KS 67114	KS-27	500	11	11-19	30	17	12-45	23	57	16-53	18	0	6-43	27	7	12-44	33	33	26-59	15	13	3-43	46	20	13-39								
CANEY MUN HOSP CANEY KS 67333	KS-28	93	19	10-27	3	100	6-87	4	25	4-77	1	100	2-98	8	63	8-65	7	71	18-81	.	.		14	7	8-52								
CEDAR VALE REG HOSP CEDAR VALE KS 67024	KS-29 *	209	11	8-19	5	40	4-73	9	22	10-65	5	20	1-68	13	0	5-48	11	55	15-68	1	0	0-97	33	15	9-37								
CENTRAL KS MED CENTER GREAT BEND KS 67530	KS-30 *	1065	11	8-15	72	18	15-38	35	17	15-44	27	26	8-40	72	22	14-34	28	50	23-58	16	38	6-48	66	18	12-33								
CHEYENNE CO HOSP SAINT FRANCIS KS 67756	KS-31 *	50	20	8-29	.	.		6	50	6-70	1	0	0-100	7	29	4-61	4	75	9-84	1	0	0-98	4	0	3-76								
CITIZENS MEDICAL CTR COLBY KS 67701	KS-32 *	259	12	9-19	7	71	11-74	4	50	12-87	6	17	1-63	13	8	7-52	3	67	6-86	4	25	1-75	53	21	13-37								
CLAY CO HOSP CLAY CENTER KS 67432	KS-33	309	23	12-23	15	53	11-55	12	83	13-63	12	33	5-51	14	21	7-50	19	53	23-66	6	0	1-63	39	33	21-51								
COFFEY CO HOSP BURLINGTON KS 66839	KS-34 *	181	18	9-21	5	20	2-68	3	33	3-83	6	17	4-67	7	29	5-63	2	0	6-95	6	0	3-65	37	30	13-41								
COFFEYVILLE MEM HOSP MED C COFFEYVILLE KS 67337	KS-35	1021	14	9-16	74	28	16-39	31	35	13-44	17	6	4-41	54	37	15-38	38	58	27-58	23	13	6-40	99	18	14-32								
COMANCHE CO HOSP COLDWATER KS 67029	KS-36 *	62	32	11-31	1	100	3-99	1	100	0-97	5	20	2-69	9	44	7-60	6	67	11-78	2	0	0-90	8	75	11-70								
COMMUNITY HOSP DISTRICT 1 ONAGA KS 66521	KS-37	190	13	10-21	4	25	5-79	5	40	6-75	8	13	7-64	10	40	6-57	10	40	17-72	5	0	3-71	29	28	10-41								
COMMUNITY MEM HOSP MARYSVILLE KS 66508	KS-38 *	421	14	9-18	28	29	13-47	19	26	15-55	10	20	3-51	33	33	12-41	7	29	12-75	17	18	8-49	46	24	11-36								

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
ALLEN CO HOSP IOLA KS 66749	5	60	6-76	6	17	10-77	19	16	2-34	.	.		64	3	2-15	48	10	2-19	4	0	0-100	30	10	1-21	14	7	0-62			
ALLEN SUSAN B MEM HOSP EL DORADO KS 67042	11	18	6-59	4	50	11-87	12	8	0-43	2	0	0-100	67	1	2-14	59	0	1-16	9	0	0-100	48	4	1-16	59	0	0-13			
ANDERSON CO HOSP GARNETT KS 66032	5	60	4-74	.	.		1	100	0-99	.	.		22	9	1-27	11	0	0-57	2	0	0-100	12	8	1-41	2	0	0-100			
ARKANSAS CITY MEM HOSP ARKANSAS CITY KS 67005	5	20	5-75	4	25	9-85	15	0	2-38	2	0	0-100	49	10	2-18	23	0	0-29	10	0	0-92	31	10	1-21	27	0	0-24			
ASBURY HOSP SALINA KS 67401	27	19	14-54	13	46	14-64	62	13	5-22	.	.		161	7	2-9	80	4	1-14	25	0	0-66	69	4	2-14	193	1	0-5			
ASHLAND DIST HOSP ASHLAND KS 67831	1	0	1-97	1	0	0-97	.	.		.	.		1	100	0-99	1	0	0-100	.	.		1	0	0-100	1	0	0-100			
ATCHISON HOSP ATCHISON KS 66002	11	9	12-67	1	100	1-97	26	4	3-30	1	0	0-100	51	6	1-16	16	0	0-36	7	0	0-100	25	8	1-24	28	4	0-26			
ATCHISON HOSP/LT ATCHISON KS 66002	.	.		.	.		1	0	0-100	.	.		.	.		.	.		.	.		1	0	0-100	2	0	0-100			
ATTICA DIST HOSP 1 ATTICA KS 67009	1	0	0-100	1	0	2-98	1	0	0-99	.	.		10	10	0-50	3	0	0-96	3	0	0-100	8	0	0-60	4	0	0-100			
AUGUSTA MEDICAL COMPLEX IN AUGUSTA KS 67010	10	40	11-67	3	33	3-83	3	33	0-82	.	.		32	6	1-20	10	0	0-53	4	0	0-100	23	4	1-26	8	0	0-76			
AXTELL CHRISTIAN HOSP NEWTON KS 67114	6	17	2-66	5	20	8-77	20	0	2-32	.	.		62	11	2-16	36	3	0-24	7	0	0-100	44	0	1-17	52	0	0-13			
BAXTER MEMORIAL HOSP BAXTER SPRINGS KS 66713	1	0	0-99	3	100	6-88	3	33	0-82	1	0	0-100	15	0	0-35							20	5	0-29	4	0	0-99			
BEHAVIORAL MEDICINE CENTER PARSONS, KS 67357																						1	0	0-99						
BETHANY MEDICAL CTR KANSAS CITY KS 66102	16	19	6-51	34	50	22-56	56	7	3-20	59	0	0-26	188	7	3-11	72	7	2-15	10	0	0-78	176	6	3-10	117	1	1-7			
BETHEL OEACONESS HOSPITAL NEWTON KS 67114	4	25	5-81	11	18	10-62	29	3	3-28	.	.		51	0	1-16	32	3	1-22	5	0	0-100	39	5	1-19	19	0	0-32			
CANEY MUN HOSP CANEY KS 67333	2	50	3-91	1	0	0-97	.	.		.	.		10	10	0-48	3	0	0-84	1	0	0-97	2	0	0-96	8	0	0-92			
CEDAR VALE REG HOSP CEDAR VALE KS 67024	5	20	5-74	.	.		1	0	0-99	.	.		28	4	2-25	6	17	0-70	.	.		11	0	0-44	8	0	0-93			
CENTRAL KS MED CENTER GREAT BEND KS 67530	14	29	11-61	11	36	13-66	22	5	1-28	11	0	0-100	126	6	2-10	83	2	1-13	25	0	0-52	58	0	1-15	103	1	0-8			
CHEYENNE CO HOSP SAINT FRANCIS KS 67756							1	0	0-100	.	.		6	17	0-72	4	25	1-74	.	.		5	0	0-69	3	0	0-95			
CITIZENS MEDICAL CTR COLBY KS 67701	4	25	3-78	2	50	2-90	3	0	0-82	.	.		29	3	1-23	9	11	0-61				25	0	1-24	8	0	0-66			
CLAY CO HOSP CLAY CENTER KS 67432	6	50	3-68	7	57	13-76	3	0	0-88	.	.		31	10	2-23	7	0	1-57	3	0	0-100	22	0	0-26	7	0	0-96			
COFFEY CO HOSP BURLINGTON KS 66839	1	0	1-97	1	0	1-97	3	0	0-86	.	.		23	13	1-27	5	20	0-70	1	0	0-100	13	0	0-40	6	0	0-91			
COFFEYVILLE MEM HOSP MED C COFFEYVILLE KS 67337	7	43	9-72	9	44	18-76	28	11	3-29	.	.		111	5	2-12	65	3	1-16	8	0	0-100	74	5	2-14	51	0	0-14			
COMANCHE CO HOSP COLDWATER KS 67029	.	.		1	0	0-97	.	.		.	.		8	0	1-53	.	.		.	.		8	38	0-54	3	0	0-98			
COMMUNITY HOSP OISTRICT 1 ONAGA KS 66521	6	0	1-66	.	.		.	.		.	.		13	0	1-39	7	0	0-66	1	0	0-100	12	8	1-41	9	0	0-68			
COMMUNITY MEM HOSP MARYSVILLE KS 66508	5	20	2-71	4	25	6-81	22	18	2-30	.	.		79	6	2-14	12	0	1-42	4	0	0-100	21	14	1-27	20	0	0-35			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease								
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent					
CUSHING MEM HOSP LEAVENWORTH KS 66048	KS-39	359	16	9-19	21	43	17-57	14	29	13-59	13	31	4-47	22	45	9-43	10	80	17-72	7	43	5-66	41	15	12-38					
OECATUR CO HOSP OBERLIN KS 67749	KS-40	245	8	10-20	10	20	9-61	7	29	10-71	5	0	1-68	5	20	7-76	4	50	9-84	5	20	1-68	37	11	12-40					
OECHAIRO HOSPITAL WESTMORELAND KS 66549	KS-41 *	125	13	12-26				3	0	4-85	1	0	0-99	10	20	8-60	5	60	14-85	5	0	2-70	33	9	9-38					
EDWARDS CO HOSP KINSLEY KS 67547	KS-42	127	17	12-26	2	100	3-91	8	25	11-69	3	33	4-84	11	27	9-59	11	82	20-74	1	100	0-97	20	5	10-48					
ELLINWOOD DIST HOSP ELLINWOOD KS 67526	KS-43 *	74	22	8-25	2	100	6-95	1	100	2-98	3	33	2-82	6	67	4-67	2	50	3-91	2	50	2-90	10	10	5-55					
ELLSWORTH CO VET HOSP ELLSWORTH KS 67439	KS-44 *	207	15	11-22	5	20	3-70	15	53	16-61	1	0	0-97	22	18	10-45	12	50	19-71	9	11	2-53	41	15	8-33					
FREDONIA REGIONAL HOSPITAL FREDONIA KS 66736	KS-45 *	217	16	8-19	17	35	11-54	7	29	6-67	4	25	1-74	7	71	6-66	14	57	22-70	8	13	3-58	19	16	6-41					
GARDNER COMM MED CTR INC GARDNER KS 66030	KS-46	106	11	7-21	3	0	0-83	3	67	3-83	4	0	3-76	6	50	6-69	2	50	6-95	3	0	0-84	12	17	7-54					
GEARY COMMUNITY HOSP JUNCTION CITY KS 66441	KS-47 *	393	15	11-20	18	50	13-55	22	32	15-53	13	31	3-46	20	20	8-44	19	32	21-64	14	14	2-43	49	24	13-38					
GOVE COUNTY HOSP QUINTER KS 67752	KS-48 *	96	8	8-23				6	50	7-72	2	0	0-92	3	0	3-83	7	14	13-75	8	0	2-56	18	17	7-45					
GRAHAM CO HOSP HILL CITY KS 67642	KS-49 *	212	13	8-19	5	0	12-83	4	25	2-74	2	0	1-89	15	27	10-53	6	83	14-80	3	33	0-85	29	17	12-43					
GREELEY CO HOSP TRIBUNE KS 67879	KS-50	48	15	6-26	1	100	3-99				2	0	1-89	2	0	2-90	3	67	8-89				10	20	4-53					
GREENWOOD CO HOSP EUREKA KS 67045	KS-51	390	14	12-21	13	62	15-64	11	27	15-67	9	22	8-63	29	21	14-46	20	45	28-70	15	20	3-44	46	35	16-43					
GRISELL MEM HOSP RANSOM KS 67572	KS-52 *	58	9	6-24	1	100	1-98	2	0	1-89	2	0	2-90	3	67	3-83	1	0	1-97	3	33	1-81	7	0	2-59					
HADLEY REG MED CTR HAYS KS 67601	KS-53 *	865	9	8-15	59	25	16-41	21	19	14-53	14	14	8-53	20	35	11-48	19	32	22-64	34	12	9-39	47	13	13-38					
HALSTEAD HOSP HALSTEAD KS 67056	KS-54 *	1333	4	5-12	86	17	16-37	14	29	11-56	10	10	3-52	32	13	10-39	22	27	18-57	12	8	7-55	57	12	12-34					
HAMILTON CO HOSP SYRACUSE KS 67878	KS-55 *	57	7	8-28	1	100	3-99	4	25	8-82	1	0	0-99	6	0	4-66	3	0	7-88	1	100	0-98	6	0	3-65					
HERINGTON MUN HOSP HERINGTON KS 67449	KS-56 *	232	14	12-23	9	33	13-70	8	25	9-67	2	0	0-94	16	38	10-52	8	38	18-78	8	13	2-57	39	26	11-38					
HIAWATHA HOSP ASSOC HIAWATHA KS 66434	KS-57	363	13	8-18	15	47	7-49	4	25	8-82	4	25	2-75	10	20	7-58	13	46	18-68	4	0	2-75	40	20	10-36					
HODGEMAN CO HEALTH CENTER JETMORE KS 67854	KS-58 *	44	18	6-27				3	67	5-86	3	33	0-82	2	0	2-90	1	0	1-97	2	0	0-91	7	29	3-60					
HOISINGTON LUTHERAN HOSP HOISINGTON KS 67544	KS-59 *	197	13	7-18	5	60	9-78	5	0	4-71	3	33	0-83	5	20	3-70	1	100	2-98	6	17	5-68	27	26	10-42					
HOLTON HOSP HOLTON KS 66436	KS-60 *	130	16	9-22	6	67	6-71	13	46	12-60	4	0	1-74	6	17	5-68	1	0	1-97	10	0	2-51	17	18	7-45					
HORTON COMM HOSP HORTON KS 66439	KS-61 *	273	12	10-20	9	33	18-76	6	17	6-70	3	33	2-82	22	18	9-44	6	33	15-81	7	14	3-61	31	19	12-43					
HOSP DIST 1 OF CRAWFORD CO GIRARD KS 66743	KS-62 *	198	16	9-20	11	45	19-73	9	22	10-66	6	33	3-65	13	23	8-52	6	83	12-78	4	25	2-74	11	36	5-52					
HOSP DISTRICT 5 HARPER COU HARPER KS 67058	KS-63 *	156	17	9-22	4	50	7-82	4	25	5-79	3	67	5-86	5	60	5-73	10	50	16-71	10	10	3-52	24	21	9-42					
HOSPITAL DIST 1 OF RICE CO LYONS KS 67554	KS-64 *	211	20	10-22	10	70	14-69	12	42	11-60	8	25	7-65	13	46	8-53	10	50	18-73	9	22	2-54	29	24	9-39					

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CUSHING MEM HOSP LEAVENWORTH KS 66048	2	100	6-94	9	22	10-66	17	6	1-34	.	.	.	42	7	1-17	11	9	0-47	2	0	0-100	23	0	1-26	14	0	0-58
DECATUR CO HOSP OBERLIN KS 67749	12	17	8-59	7	43	11-75	1	100	1-97	.	.	.	32	0	1-21	14	0	0-41	3	0	0-100	25	4	1-25	10	0	1-46
DECHAIRD HOSPITAL WESTMORELAND KS 66549	15	13	8-55	3	33	6-87	.	.	.	.	.	.	1	0	0-97	4	25	0-79	.	.	.	20	0	1-29	1	0	0-97
EDWARDS CO HOSP KINSLEY KS 67547	3	0	8-90	.	.	.	1	0	0-99	.	.	.	13	0	1-39	.	.	.	.	.	.	21	5	1-27	2	0	0-99
ELLINWOOD DIST HOSP ELLINWOOD KS 67526	1	0	0-99	.	.	.	.	.	.	.	.	.	7	0	0-61	1	0	0-97	1	0	0-100	6	17	0-66	3	0	0-100
ELLSWORTH CO VET HOSP ELLSWORTH KS 67439	.	.	.	4	100	8-83	3	33	0-83	.	.	.	25	4	1-25	7	0	0-59	4	0	0-100	10	0	0-51	4	0	0-99
FREDONIA REGIONAL HOSPITAL FREDONIA KS 66736	3	33	5-86	.	.	.	6	0	0-68	.	.	.	37	0	1-18	6	0	0-73	4	0	0-100	31	6	1-21	5	0	0-84
GARDNER COMM MED CTR INC GARDNER KS 66030	9	0	5-62	.	.	.	2	0	0-95	.	.	.	12	0	0-42	6	0	0-67	1	0	0-100	6	0	0-74	5	0	0-99
GEARY COMMUNITY HOSP JUNCTION CITY KS 66441	2	0	1-90	14	43	19-68	14	0	1-38	.	.	.	42	10	1-18	12	8	1-42	2	0	0-100	36	0	1-19	21	0	0-38
GOVE COUNTY HOSP QUINTER KS 67752	.	.	.	1	100	1-97	2	0	0-96	.	.	.	9	0	0-52	4	0	0-92	.	.	.	8	0	0-57	6	0	0-95
GRAHAM CO HOSP HILL CITY KS 67642	3	33	4-85	1	100	3-99	.	.	.	.	.	.	26	4	1-24	3	33	0-83	2	0	0-100	13	8	0-39	14	0	0-66
GREELEY CO HOSP TRIBUNE KS 67879	.	.	.	.	.	.	.	.	.	.	.	.	9	0	0-53	3	0	0-85	2	0	0-100	4	0	0-90	2	0	0-100
GREENWOOD CO HOSP EUREKA KS 67045	1	0	0-99	3	100	10-91	12	0	2-44	.	.	.	41	2	2-19	20	15	3-34	3	0	0-100	19	0	1-30	21	0	0-31
GRISELL MEM HOSP RANSOM KS 67572	1	0	0-97	1	0	2-98	.	.	.	.	.	.	8	13	0-54	.	.	.	.	.	.	4	0	0-84	4	0	0-100
HADLEY REG MED CTR HAYS KS 67601	5	0	4-73	6	17	15-82	36	8	5-28	81	0	0-12	53	6	2-17	65	0	1-15	15	0	0-99	55	9	2-16	51	0	0-13
HALSTEAD HOSP HALSTEAD KS 67056	1	0	1-97	8	0	10-69	15	0	1-37	14	7	0-93	116	2	2-11	90	1	0-14	20	0	0-60	77	8	2-13	287	1	0-4
HAMILTON CO HOSP SYRACUSE KS 67878	1	0	0-97	.	.	.	.	.	.	.	.	.	7	0	0-59	2	0	1-89	.	.	.	6	0	0-72	1	0	0-100
HERINGTON MUN HOSP HERINGTON KS 67449	10	10	6-60	9	33	18-76	1	0	0-99	.	.	.	35	0	1-20	2	0	0-94	1	0	0-100	20	0	1-29	10	10	1-46
HIAWATHA HOSP ASSOC HIAWATHA KS 66434	1	100	1-97	2	0	6-95	.	.	.	.	.	.	40	8	1-18	13	8	1-40	3	0	0-100	28	4	1-23	11	9	0-76
HODGEMAN CO HEALTH CENTER JETMORE KS 67854	1	0	0-99	.	.	.	.	.	.	.	.	.	3	0	0-99	5	40	0-68	2	0	0-100	1	100	0-100	1	0	0-100
HOISINGTON LUTHERAN HOSP HOISINGTON KS 67544	2	50	4-93	3	0	4-85	.	.	.	.	.	.	18	6	1-31	6	17	0-69	2	0	0-100	9	0	0-55	3	0	0-100
HOLTON HOSP HOLTON KS 66436	1	0	0-100	1	100	0-97	.	.	.	.	.	.	14	7	2-39	8	0	2-55	.	.	.	7	0	0-63	3	0	0-99
HORTON COMM HOSP HORTON KS 66439	2	50	4-92	7	14	9-71	1	0	0-97	.	.	.	28	0	1-23	16	19	2-36	3	0	0-100	22	0	1-27	6	0	0-77
HOSP DIST 1 OF CRAWFORD CO GIRARD KS 66743	1	100	2-98	2	50	1-89	1	0	0-100	.	.	.	20	10	1-29	7	0	0-67	1	0	0-100	19	0	1-30	13	0	0-51
HOSP DISTRICT 5 HARPER COU HARPER KS 67058	2	0	0-91	.	.	.	.	.	.	.	.	.	15	0	0-36	5	40	3-70	2	0	0-100	8	0	0-56	7	14	0-89
HOSPITAL DIST 1 OF RICE CO LYONS KS 67554	3	33	4-86	2	50	1-89	.	.	.	.	.	.	23	0	1-26	1	0	0-100	.	.	.	27	4	1-23	8	0	0-90

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Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease								
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent					
HOSPITAL DISTRICT #1 OF SU CALDWELL, KS 67022	KS-65 *	130	12	9-23				9	56	13-70							12	8	6-52	4	75	11-87	2	0	1-89	20	15	8-44			
HOSPITAL DISTRICT #6 OF HA ANTHONY KS 67003	KS-66 *	180	10	9-20	5	40	7-76	8	0	9-67	12	0	3-46	13	15	8-53	5	20	7-77	8	25	2-57	20	20	8-44					
HUMANA HOSPITAL DODGE CITY DODGE CITY KS 67801	KS-67 *	854	11	8-16	37	22	14-44	26	42	13-47	32	13	7-35	39	23	14-41	29	52	23-58	12	8	4-49	59	22	12-34					
HUMANA HOSPITAL-OVERLAND P OVERLAND PARK KS 66215	KS-68	1139	9	8-15	81	12	15-37	31	23	16-48	31	10	7-35	39	28	12-39	41	44	25-55	28	21	13-47	70	21	13-33					
HUTCHINSON HOSP CORP HUTCHINSON KS 67501	KS-69	1714	12	9-16	106	30	17-37	68	26	20-43	41	32	8-34	106	18	17-34	62	37	28-53	24	8	8-43	123	23	14-31					
JEFFERSON CO MEM HOSP INC WINCHESTER KS 66097	KS-70 *	169	20	11-24	8	13	11-70	11	36	11-62	10	10	5-55	10	60	7-58	5	80	13-83	4	25	1-74	24	29	13-49					
JEWELL CO HOSP MANKATO KS 66956	KS-71 *	26	38	8-39	1	100	0-97	1	100	0-97	1	0	0-98	2	50	1-89	2	100	6-95	1	0	0-97	6	50	5-68					
KEARNY CO HOSP LAKIN KS 67860	KS-72 *	68	16	6-23	1	0	0-99				1	0	0-99	3	33	1-81	1	100	2-98	1	0	0-98	16	38	8-50					
KINGMAN COMM HOSP KINGMAN KS 67068	KS-73 *	229	17	8-19	16	31	7-49	7	29	5-64	6	17	1-63	6	0	5-68	6	67	9-75	9	0	3-55	26	23	10-43					
KIOWA CO MEM HOSP GREENSBURG KS 67054	KS-74 *	142	13	11-24	4	50	14-90	9	33	9-64	2	0	1-89	6	17	8-72	9	44	15-72	9	11	2-53	21	14	11-48					
KIOWA DISTRICT HOSP KIOWA KS 67070	KS-75	116	20	10-25	2	50	0-91	8	38	9-67	6	17	1-63	3	0	2-82	10	60	23-78	5	40	7-76	25	24	9-41					
LABETTE CO MEDICAL CENTER PARSONS KS 67357	KS-76 *	933	10	8-15	59	34	14-38	30	27	15-47	18	17	10-51	35	23	12-40	27	30	24-60	26	19	5-37	110	15	13-30					
LANE CO HOSP DIGHTON KS 67839	KS-77 *	29	24	9-39	1	100	0-97	1	0	1-97	1	0	0-97	1	0	0-97	7	29	13-76	2	0	0-92	3	33	0-82					
LAWRENCE MEMORIAL HOSP LAWRENCE KS 66044	KS-78	987	14	9-16	76	24	14-36	43	37	17-44	18	22	6-44	50	22	13-37	30	50	22-56	21	19	4-39	93	24	12-29					
LINCOLN CO HOSP LINCOLN KS 67455	KS-79 *	114	17	14-29	.			.			6	0	2-64	8	13	8-64	5	60	13-83	11	27	11-62	22	18	18-57					
LINOSBORG COMM HOSP LINOSBORG KS 67456	KS-80	214	17	9-20	2	50	1-89	6	50	9-74	7	29	1-59	7	14	10-71	4	25	6-80	4	25	5-79	25	44	14-50					
LOGAN CO HOSP OAKLEY KS 67748	KS-81 *	115	18	10-24	2	0	3-91	5	60	6-75	2	0	0-90	12	33	7-54	7	57	15-78	6	0	3-66	19	32	9-47					
MEADE DISTRICT HOSP MEADE KS 67864	KS-82	93	15	6-21	4	50	6-80	2	100	3-91	3	0	0-83	4	25	3-76	3	67	5-86	1	0	0-97	10	30	6-56					
MEDICINE LODGE MEM HOSP MEDICINE LODGE KS 67104	KS-83 *	198	17	9-20	7	57	6-65	9	22	8-62	6	33	5-68	8	13	9-67	9	44	15-72	8	25	7-65	27	15	8-39					
MEMORIAL HOSP MCPHERSON KS 67460	KS-84 *	437	13	9-17	23	35	15-53	12	25	8-55	10	20	4-54	30	33	12-43	15	73	21-68	10	10	5-55	42	19	9-34					
MEMORIAL HOSP CORP OF TOPE TOPEKA KS 66607	KS-85	986	8	7-14	57	14	12-36	23	43	12-48	20	35	8-45	40	23	13-39	22	50	22-61	16	38	9-51	56	9	11-34					
MEMORIAL HOSP OF DICKINSON ABILENE KS 67410	KS-86 *	362	17	12-22	21	57	14-54	23	30	17-55	12	8	3-47	27	26	14-47	21	33	25-66	4	25	6-80	50	20	11-35					
MEMORIAL HOSPITAL MANHATTAN KS 66502	KS-87 *	171	8	6-17	16	19	6-47	6	33	6-70	2	0	0-96	7	14	6-66	4	50	13-88	2	0	0-91	14	14	6-49					
MERCY HOSP FORT SCOTT KS 66701	KS-88 *	1171	11	9-16	95	18	14-34	42	38	17-44	34	12	9-38	78	22	16-36	38	61	28-59	19	16	7-45	83	16	13-32					
MERCY HOSP INDEPENDENCE KS 67301	KS-89	659	14	10-18	30	23	11-43	32	38	16-48	21	24	7-43	39	26	14-41	21	43	23-63	14	14	7-52	87	17	11-30					
MERCY HOSP INC MOUNORIOGE KS 67107	KS-90 *	124	9	7-20	3	67	5-86	7	14	11-73	3	0	1-82	7	14	5-64	2	100	2-90	.	.		11	9	5-53					

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories												Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HOSPITAL DISTRICT #1 OF SU CALDWELL, KS 67022	.	.		2	0	3-91	.	.		.	.		14	14	0-38	10	20	5-54	.	.		19	0	1-30	6	0	0-94
HOSPITAL DISTRICT #6 OF HA ANTHONY KS 67003	8	50	9-69	2	100	2-90	1	0	0-98	.	.		20	0	0-29	4	0	0-87	1	0	0-100	23	0	1-26	8	0	0-67
HUMANA HOSPITAL DODGE CITY DODGE CITY KS 67801	7	0	6-68	11	36	10-62	19	11	1-32	4	0	0-100	103	6	3-15	91	5	2-14	11	0	0-100	45	2	1-17	61	0	0-12
HUMANA HOSPITAL-OVERLAND P OVERLAND PARK KS 66215	17	12	7-51	17	29	16-61	31	6	3-27	8	0	0-97	140	3	2-11	43	0	1-19	15	0	0-56	101	3	2-11	127	2	0-7
HUTCHINSON HOSP CORP HUTCHINSON KS 67501	9	22	10-68	22	41	22-63	91	7	6-20	13	15	0-96	151	4	2-10	72	0	0-14	24	0	0-63	126	5	2-11	173	1	0-6
JEFFERSON CO MEM HOSP INC WINCHESTER KS 66097	2	100	8-97	4	0	4-78	6	0	0-66	.	.		23	9	1-26	8	0	0-55	.	.		2	0	0-97	3	0	0-99
JEWELL CO HOSP MANKATO KS 66956	.	.		.	.		.	.		.	.		5	20	1-68	.	.		.	.		.	.		1	0	0-100
KEARNY CO HOSP LAKIN KS 67860	2	50	3-92	.	.		.	.		.	.		6	0	0-79	3	0	0-82	.	.		7	0	1-57	2	0	0-100
KINGMAN COMM HOSP KINGMAN KS 67068	3	33	0-83	3	67	6-87	2	0	0-95	.	.		30	7	1-23	11	0	0-45	1	0	0-100	18	6	1-31	7	0	0-58
KIOWA CO MEM HOSP GREENSBURG KS 67054	2	50	3-91	2	50	2-90	1	0	0-100	.	.		14	0	0-38	2	0	0-100	.	.		17	6	1-32	6	0	0-92
KIOWA DISTRICT HOSP KIOWA KS 67070	2	100	2-90	.	.		1	0	0-100	.	.		21	0	1-28	.	.		1	0	0-100	5	0	0-73	4	0	0-99
LABETTE CO MEDICAL CENTER PARSONS KS 67357	4	75	11-87	2	50	2-90	34	9	3-26	11	0	0-100	100	1	2-11	41	5	1-20	11	0	0-99	75	1	1-12	101	0	0-8
LANE CO HOSP DIGHTON KS 67839	.	.		2	100	4-92							3	0	0-95							1	0	0-98	1	0	0-100
LAWRENCE MEMORIAL HOSP LAWRENCE KS 66044	1	0	2-99	22	27	16-57	44	2	2-21	3	0	0-100	105	5	3-14	37	5	1-20	6	0	0-100	68	6	2-14	78	3	0-9
LINCOLN CO HOSP LINCOLN KS 67455	1	0	0-99	5	20	7-77	.	.		.	.		6	33	0-67	1	0	1-97	.	.		9	0	0-51	2	0	0-100
LINOSBORG COMM HOSP LINOSBORG KS 67456	10	30	7-61	2	0	2-90	6	17	1-62	.	.		23	13	1-27	3	33	0-87	1	0	2-98	15	13	1-35	13	0	0-75
LOGAN CO HOSP OAKLEY KS 67748	1	0	0-97	1	0	1-97	.	.		.	.		18	0	0-31	3	0	1-81	1	0	0-100	10	0	0-47	7	0	0-82
MEADE DISTRICT HOSP MEADE KS 67864	2	100	2-91				3	0	0-85	.	.		15	0	0-37	6	0	2-63	2	0	0-100	5	0	0-80	5	0	0-98
MEDICINE LODGE MEM HOSP MEDICINE LODGE KS 67104	1	100	0-97	2	50	4-92	7	14	1-58				21	5	2-30	10	20	0-50	3	0	0-100	14	14	1-37	12	0	0-58
MEMORIAL HOSP MCPHERSON KS 67460	8	38	9-70	3	33	7-88	18	11	1-33	1	0	0-100	58	3	2-16	13	0	0-42	7	0	0-100	30	3	1-21	21	0	0-35
MEMORIAL HOSP CORP OF TOPE TOPEKA KS 66607	8	13	11-72	19	32	20-64	25	4	2-28	98	0	0-10	65	2	2-15	57	4	1-16	11	0	0-100	63	0	1-13	49	0	0-14
MEMORIAL HOSP OF DICKINSON ABILENE KS 67410	6	33	5-71	4	0	7-82	2	0	0-97				38	8	1-19	14	0	0-40				22	0	1-27	16	6	0-39
MEMORIAL HOSPITAL MANHATTAN KS 66502	3	33	1-82	2	0	2-91	4	0	0-74	.	.		25	4	0-24	18	0	0-35	13	0	0-100	9	11	0-57	5	0	0-98
MERCY HOSP FORT SCOTT KS 66701	11	9	7-60	15	47	19-67	23	9	4-34	9	0	0-99	131	2	2-11	188	2	1-10	26	0	0-23	60	0	2-15	47	2	0-15
MERCY HOSP INDEPENDENCE KS 67301	13	31	10-60	8	63	16-77	29	7	2-25				65	3	2-15	16	6	1-36	6	0	0-100	40	8	1-19	48	0	0-14
MERCY HOSP INC MOUNDRIDGE KS 67107	4	0	9-85				2	0	0-93				22	5	1-27	2	0	0-100	2	0	0-100	9	0	0-53	7	0	0-72

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	Comment/ Reference	Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MIAMI CO HOSP PAOLA KS 66071	KS-91 *	178	20	11-23	3	67	3-83	10	40	9-62	3	0	1-81	16	19	10-52	7	71	18-81	6	67	1-63	22	32	11-48
MINNEOLA DISTRICT HOSP MINNEOLA KS 67865	KS-92 *	120	11	10-25	3	0	2-82	8	38	12-70	4	0	1-74	14	21	9-53	7	0	18-81	2	0	0-91	13	15	8-53
MITCHELL CO COMM HOSP BELOIT KS 67420	KS-93 *	443	12	9-18	17	24	9-50	17	29	11-53	23	4	5-37	21	48	11-47	24	50	21-59	3	33	6-87	59	24	14-37
MORRIS CO HOSP COUNCIL GROVE KS 66846	KS-94 *	160	16	9-22	5	80	8-78	9	33	10-66	5	20	4-72	13	38	9-54	10	30	18-73	2	0	0-92	14	21	5-47
MORTON COUNTY HOSPITAL ELKHART KS 67950	KS-95	145	10	9-22	3	33	3-83	2	100	3-91	5	0	2-68	6	0	5-68	3	67	8-90	6	50	12-79	25	8	10-43
MT CARMEL MEDICAL CENTER PITTSBURG KS 66762	KS-96	1279	14	9-16	88	39	17-38	37	41	16-45	47	17	8-32	85	21	15-34	48	42	25-53	47	13	9-35	105	23	14-31
NEMAHA VALLEY COMM HOSP SENECA KS 66538	KS-97 *	259	13	10-20	9	22	4-57	16	44	11-53	13	15	6-51	21	19	11-48	3	0	8-89	4	25	1-74	40	30	15-43
NEOSHO MEM HOSP CHANUTE KS 66720	KS-98 *	573	18	10-18	33	39	12-44	16	44	15-58	15	27	5-45	38	42	13-41	29	48	25-60	9	11	4-56	58	19	11-33
NESS CO HOSP DIST 2 NESS CITY KS 67560	KS-99 *	157	8	8-20	5	40	5-73	2	0	4-92	6	0	6-70	6	17	6-69	10	10	18-73	.	.	.	9	0	5-57
NEWMAN MEMORIAL CO HOSP EMPORIA KS 66801	KS-100	772	10	8-15	33	21	11-41	28	18	13-46	10	60	6-56	42	24	12-38	33	33	25-58	18	17	5-43	83	17	11-30
NEWTON WM MEM HOSP WINFIELD KS 67156	KS-101	604	13	9-17	32	22	13-45	23	35	12-48	6	17	2-63	25	28	11-45	21	38	24-65	31	10	9-40	64	25	12-34
NORTHWEST KANSAS MED CENTE GOODLAND KS 67735	KS-102	194	12	9-20	11	27	5-53	6	33	6-70	9	33	8-63	11	18	8-58	7	43	13-76	5	0	1-68	23	22	9-43
NORTON CO HOSP NORTON KS 67654	KS-103*	205	14	8-19	13	46	9-55	9	44	11-66	5	40	2-69	12	17	9-57	4	25	7-82	3	33	1-82	27	11	7-36
NORTON MAUDE MEM CITY HOSP COLUMBUS KS 66725	KS-104	165	21	10-23	12	58	12-62	8	25	8-66	5	0	1-68	8	38	7-64	5	60	12-83	8	0	2-56	28	25	9-40
OLATHE COMM HOSP OLATHE KS 66061	KS-105*	1134	10	8-16	64	22	16-41	29	28	15-48	24	17	7-40	58	16	13-35	28	46	25-61	40	15	7-33	105	10	13-31
OSBORNE CO MEM HOSP OSBORNE KS 67473	KS-106*	132	14	10-24	2	50	3-92	6	33	8-72	10	20	3-52	15	27	10-53	9	22	19-76	8	13	2-56	13	23	8-54
OSWEGO CITY HOSP OSWEGO KS 67356	KS-107*	144	13	8-21	1	100	0-97	5	40	3-70	2	0	1-89	5	20	4-71	.	.	.	18	11	6-45	20	30	10-47
OTTAWA CO HOSP MINNEAPOLIS KS 67467	KS-108*	136	18	9-22	3	33	2-82	8	50	8-66	2	0	0-92	7	43	4-62	8	25	14-74	3	0	0-86	14	29	8-51
PHILLIPS CO HOSP PHILLIPSBURG KS 67661	KS-109	294	15	8-17	4	50	5-80	1	0	1-97	9	0	2-52	21	57	12-50	10	50	17-72	18	22	8-48	26	23	8-39
PLAINVILLE RURAL HOSP PLAINVILLE KS 67663	KS-110	111	12	10-26	2	0	5-93	6	17	7-72	2	0	3-91	10	40	8-60	7	0	9-70	8	0	1-56	18	28	13-54
PRATT REGIONAL MEDICAL CTR PRATT KS 67124	KS-111	506	11	9-17	30	30	13-46	7	29	8-69	15	20	8-51	27	26	11-44	12	67	19-71	21	24	6-42	57	5	11-34
PROVIDENCE ST MARGARET HC KANSAS CITY KS 66112	KS-112	1981	12	9-15	119	23	16-35	85	33	21-41	52	25	11-35	116	23	15-31	62	37	24-49	67	27	10-33	130	18	14-30
RANSOM MEM HOSP OTTAWA KS 66067	KS-113*	385	14	9-19	23	9	9-44	17	47	12-53	9	22	2-53	27	11	11-42	16	50	18-63	8	13	4-59	50	26	13-37
RAWLINS CO HOSP ATWOOD KS 67730	KS-114*	181	18	10-22	5	60	17-88	4	50	8-82	4	0	1-74	4	75	5-79	10	30	20-75	3	0	0-84	20	40	9-46
REPUBLIC CO HOSP BELLEVILLE KS 66935	KS-115*	339	14	8-17	16	31	10-52	16	44	10-53	4	50	2-75	24	29	11-45	12	25	15-66	4	0	1-74	37	27	13-41
RIVERSIDE HOSP WICHITA KS 67203	KS-116	457	14	9-18	22	18	17-56	12	25	9-58	8	50	3-58	29	28	12-44	12	83	20-71	34	18	7-36	44	20	10-35

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
MIAMI CO HOSP PAOLA KS 66071	5	40	7-78	1	0	0-97	1	0	0-98				16	13	1-34	3	0	0-95	.			4	0	1-74	6	0	0-94			
MINNEOLA DISTRICT HOSP MINNEOLA KS 67865	1	0	1-97	1	100	2-98	7	0	1-57				5	20	0-71	.			4	0	0-100	16	0	1-34	10	0	0-73			
MITCHELL CO COMM HOSP BELOIT KS 67420	1	0	1-97	7	14	8-70	1	0	0-98				28	0	1-23	18	0	1-33	4	0	0-100	30	7	1-21	33	0	0-21			
MORRIS CO HOSP COUNCIL GROVE KS 66846	5	0	2-71	1	0	1-97	6	0	0-65				17	6	0-33	5	20	1-67	.	.		19	16	1-29	9	0	0-56			
MORTON COUNTY HOSPITAL ELKHART KS 67950	1	100	3-99	1	0	2-99	.	.					26	0	1-25	1	0	0-100	1	0	0-100	16	0	1-33	3	33	0-92			
MT CARMEL MEDICAL CENTER PITTSBURG KS 66762	6	33	3-68	19	32	16-59	30	7	3-28	79	0	0-20	135	7	2-10	62	2	1-16	17	0	0-98	80	3	2-13	47	2	0-14			
NEMAHA VALLEY COMM HOSP SENECA KS 66538	.	.		2	50	6-94	2	0	0-92	.	.		27	4	1-24	4	0	0-78	1	0	0-100	31	6	1-21	7	0	0-72			
NEOSHO MEM HOSP CHANUTE KS 66720	12	25	10-63	9	56	17-75	12	42	1-42	1	0	0-100	56	7	1-14	19	16	1-32	7	0	0-100	55	9	1-15	24	0	0-26			
NESS CO HOSP DIST 2 NESS CITY KS 67560	4	75	10-87	2	0	1-89	1	0	0-100	.	.		31	6	1-22	5	0	0-73				23	0	1-26	9	11	0-60			
NEWMAN MEMORIAL CO HOSP EMPORIA KS 66801	6	33	5-70	7	29	7-68	29	7	3-28	6	0	0-100	83	1	1-12	31	3	1-23	6	0	0-100	69	3	2-14	49	6	0-14			
NEWTON WM MEM HOSP WINFIELD KS 67156	11	27	13-67	4	0	13-89	19	0	2-32	.			80	10	2-13	13	0	0-41	9	0	0-100	40	5	1-17	28	0	0-27			
NORTHWEST KANSAS MED CENTE GOODLAND KS 67735	3	0	0-84	1	0	2-98	.	.		.	.		28	0	1-23	6	0	0-63	.			10	30	0-47	5	0	0-93			
NORTON CO HOSP NORTON KS 67654	9	0	3-58	.	.		.	.		.			28	4	1-22	2	0	0-97	1	0	0-100	15	20	1-35	7	14	0-63			
NORTON MAUDE MEM CITY HOSP COLUMBUS KS 66725	3	100	4-85	2	50	2-91	1	0	0-100	.	.		12	0	0-43	9	0	0-52	1	0	0-100	14	14	1-37	4	0	0-98			
OLATHE COMM HOSP OLATHE KS 66061	10	10	10-66	11	18	15-69	59	14	3-19	4	0	0-100	134	4	2-11	97	7	2-14	14	0	0-82	85	7	2-12	85	4	0-9			
OSBORNE CO MEM HOSP OSBORNE KS 67473	2	0	3-91				3	0	0-86				14	0	0-38	5	0	0-75	1	0	0-100	18	11	0-31	2	0	0-100			
OSWEGO CITY HOSP OSWEGO KS 67356	1	0	1-97	4	50	10-86	2	0	0-96				12	8	0-42	10	0	1-47				12	0	0-41	7	0	0-88			
OTTAWA CO HOSP MINNEAPOLIS KS 67467	5	40	4-74	2	0	2-90	6	0	0-63				12	0	0-43	3	0	0-83				16	13	1-34	9	0	0-58			
PHILLIPS CO HOSP PHILLIPSBURG KS 67661	3	33	4-85	8	38	11-70	13	0	1-40				29	7	1-22	5	20	0-77	2	0	0-100	32	6	1-20	15	0	0-68			
PLAINVILLE RURAL HOSP PLAINVILLE KS 67663	2	0	1-90	3	0	3-83	.	.		.	.		11	0	0-48	1	0	0-100	1	0	0-100	11	0	0-44	2	0	0-99			
PRATT REGIONAL MEDICAL CTR PRATT KS 67124	4	75	7-83	4	0	5-80	2	0	0-92	3	0	0-100	80	5	2-14	25	4	0-26				39	3	1-18	26	4	0-23			
PROVIDENCE ST MARGARET HC KANSAS CITY KS 66112	18	22	9-53	22	27	22-63	56	7	4-21	28	0	0-62	184	3	2-9	64	3	2-16	18	0	0-88	196	6	2-9	137	0	0-6			
RANSOM MEM HOSP OTTAWA KS 66067	3	67	8-89	3	100	11-93	18	0	2-34	.	.		54	9	1-16	22	0	0-30	2	0	0-100	32	0	1-20	14	0	0-52			
RAWLINS CO HOSP ATWOOD KS 67730	7	43	10-74	2	50	4-93	1	0	0-100	.	.		25	8	2-28	8	0	1-53	6	0	0-100	12	8	0-42	14	0	0-45			
REPUBLIC CO HOSP BELLEVILLE KS 66935	1	0	1-97	2	0	3-91	4	0	0-81				40	0	1-17	32	3	1-22	6	0	0-100	15	7	1-35	17	0	0-39			
RIVERSIDE HOSP WICHITA KS 67203	4	75	3-77	13	38	14-63	15	20	5-45	6	0	0-99	38	5	1-19	18	0	0-33	1	0	0-100	35	0	1-19	29	0	0-24			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RUSH CO MEM HOSP LA CROSSE KS 67548	KS-117*	141	14	10-23	2	50	0-89	8	25	9-67	3	0	2-81	11	18	9-58	2	50	6-94	9	22	3-55	27	30	15-49
RUSSELL CITY HOSP RUSSELL KS 67665	KS-118	248	19	8-18	6	33	7-71	9	56	9-63	4	25	1-74	17	41	9-48	13	46	20-70	7	0	1-59	17	12	7-46
SABETHA COMM HOSP SABETHA KS 66534	KS-119*	163	13	9-21	15	13	11-55	6	67	8-73	6	33	1-63	8	13	7-64	5	40	11-81	1	0	0-99	24	17	8-41
SALEM HOSP INC HILLSBORO KS 67063	KS-120*	145	19	9-21	3	33	6-87	7	14	7-67	6	83	5-68	11	64	7-55	6	50	13-80	13	8	4-47	14	29	7-50
SATANTA DIST HOSP SATANTA KS 67870	KS-121*	60	17	9-30	3	67	4-85	2	50	2-90	4	25	0-76	10	10	7-58	.	.		5	0	6-75	9	33	4-56
SCOTT CO HOSP SCOTT CITY KS 67871	KS-122	165	16	8-20	10	50	8-61	6	67	5-69	2	0	0-91	6	33	5-68	7	43	11-73	11	9	3-50	16	19	6-45
SEQAN CITY HOSP SEQAN KS 67361	KS-123	88	18	7-23	1	100	2-98	4	25	5-79	2	50	1-89	2	50	2-90	4	75	9-84	4	25	2-75	15	27	6-47
SHAWNEE MISSION MED CTR SHAWNEE MISSION KS 66201	KS-124	2579	10	7-14	167	25	18-35	86	30	19-39	54	19	7-30	104	19	15-32	83	42	27-49	68	10	11-34	130	18	14-30
SHERIDAN CO HOSP HOXIE KS 67740	KS-125*	69	16	9-28	4	100	10-85	5	0	10-80	3	33	5-86	2	50	2-90	4	25	11-86	1	0	0-99	7	14	5-64
SMITH CO MEM HOSP SMITH CENTER KS 66967	KS-126*	292	13	9-19	19	32	11-51	11	27	13-65	10	20	4-53	14	21	11-56	13	46	17-67	4	25	4-78	34	24	10-39
SOUTHWEST MEDICAL CTR LIBERAL KS 67901	KS-127*	521	17	9-18	44	52	20-49	7	43	6-66	15	27	6-48	21	48	11-47	31	61	25-59	12	8	3-47	48	13	7-29
SPEARVILLE DISTRICT HOSP SPEARVILLE KS 67876	KS-128*	25	0	5-35	.	.		2	0	1-89	.	.		4	0	3-76	.	.		.	.		4	0	8-84
ST ANTHONY HOSP HAYS KS 67601	KS-129*	687	11	9-17	41	17	14-42	12	17	9-56	23	9	8-42	31	29	11-41	22	36	22-62	33	24	9-40	59	29	15-38
ST CATHERINE HOSP GARDEN CITY KS 67846	KS-130	672	10	8-16	60	20	12-36	7	57	8-69	22	14	9-46	37	11	11-39	18	39	21-65	7	0	3-62	56	27	15-38
ST FRANCIS HOSP AND MED CT TOPEKA KS 66606	KS-131	2298	11	8-14	205	18	16-32	63	32	19-42	44	30	10-36	105	24	14-31	64	39	26-51	42	19	7-33	141	16	14-30
ST FRANCIS REGIONAL MEDICA WICHITA KS 67214	KS-132	4535	11	9-15	266	22	19-35	127	24	22-39	83	16	11-31	241	24	18-31	160	36	30-47	136	22	11-29	238	22	14-27
ST JOHN DISTRICT HOSP SAINT JOHN KS 67576	KS-133	77	16	7-23	.	.		2	100	2-90	2	50	5-93	7	29	7-67	1	100	0-97	4	50	1-74	13	0	4-47
ST JOHN HOSP LEAVENWORTH KS 66048	KS-134*	320	13	8-18	15	27	8-50	15	27	10-53	8	25	3-58	24	38	10-43	10	60	14-68	12	8	5-52	38	21	10-37
ST JOHNS HOSP SALINA KS 67401	KS-135	1036	10	7-14	92	22	18-39	14	57	11-57	16	13	4-42	30	33	10-41	37	35	28-60	14	14	3-45	43	26	12-38
ST JOSEPH HOSP CONCORDIA KS 66901	KS-136*	616	12	12-20	51	35	21-49	28	21	17-52	17	24	6-45	35	9	14-44	18	56	19-62	8	0	4-59	76	21	16-38
ST JOSEPH MED CTR WICHITA KS 67218	KS-137	2890	11	8-15	155	25	18-36	71	25	19-42	44	25	10-36	167	29	17-31	77	43	27-50	105	18	11-31	204	25	14-28
ST JOSEPH MEM HOSP LARNED KS 67550	KS-138*	153	16	8-20	3	67	4-84	5	60	10-80	5	40	3-70	7	57	5-63	6	50	9-75	6	0	2-64	22	23	8-43
ST LUKES HOSP MARION KS 66861	KS-139*	209	17	8-19	20	45	12-51	11	55	11-62	4	0	1-74	11	9	7-56	10	60	16-71	.			19	37	8-45
ST LUKES HOSP WELLINGTON KS 67152	KS-140*	362	14	9-18	17	53	22-67	20	40	14-53	8	13	1-55	18	39	9-47	13	38	18-68	8	25	3-58	29	21	8-38
ST MARYS HOSP MANHATTAN KS 66502	KS-141*	704	10	7-15	46	30	16-43	21	29	15-54	16	19	5-44	29	24	12-43	19	53	22-64	9	11	2-53	45	22	8-32
ST MARYS HOSPITAL EMPORIA KS 66801	KS-142	360	11	9-18	29	24	15-49	12	17	12-62	11	18	2-48	22	5	10-46	19	53	21-63	6	0	3-66	26	15	10-43

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
RUSH CO MEM HOSP LA CROSSE KS 67548	.	.		.	.		.	.					13	8	1-39	1	0	0-99	2	0	0-100	17	6	1-32	11	0	0-46			
RUSSELL CITY HOSP RUSSELL KS 67665	2	0	1-90	1	100	2-98	.	.		1	0	0-100	35	6	0-19	10	0	0-51	1	0	0-100	28	7	1-23	8	13	0-55			
SABETHA COMM HOSP SABETHA KS 66534	2	50	1-90	2	0	3-92	4	0	0-75	1	0	0-100	18	0	0-31	6	0	0-79				7	0	0-59	13	0	0-65			
SALEM HOSP INC HILLSBORO KS 67063	.	.		.	.		7	0	1-57	.	.		18	11	0-31	6	0	0-65	1	0	0-100	11	0	0-44	6	0	0-85			
SATANTA DIST HOSP SATANTA KS 67870	2	100	10-100	.	.		.	.		.	.		4	0	0-87	4	0	0-86	.	.		4	0	0-85	6	0	0-90			
SCOTT CO HOSP SCOTT CITY KS 67871	5	20	4-73	1	100	3-99	6	0	0-67	.	.		23	4	1-26	1	0	0-100	.	.		14	7	1-37	9	11	0-80			
SEDAN CITY HOSP SEDAN KS 67361	.	.		.	.		2	0	0-96	1	0	0-100	3	0	0-98	3	0	0-82	1	0	0-100	10	10	0-49	3	0	0-97			
SHAWNEE MISSION MED CTR SHAWNEE MISSION KS 66201	11	18	4-55	10	10	12-67	89	10	3-17	118	0	0-8	260	3	2-9	105	3	1-12	26	0	0-58	223	7	2-9	234	0	0-5			
SHERIDAN CO HOSP HOXIE KS 67740	.	.		.	.		2	0	0-96	.	.		10	10	0-50	.	.		.	.		7	14	0-59	4	0	0-99			
SMITH CO MEM HOSP SMITH CENTER KS 66967	4	0	0-78	2	50	6-95	1	0	0-100	.	.		37	8	1-19	10	10	0-47	13	0	0-100	23	4	1-26	9	0	0-77			
SOUTHWEST MEDICAL CTR LIBERAL KS 67901	9	44	7-65	3	0	8-90	12	0	2-44	6	0	0-100	88	5	1-12	8	13	0-62	7	0	0-100	26	0	1-23	21	0	0-33			
SPEARVILLE DISTRICT HOSP SPEARVILLE KS 67876	.	.		.	.		1	0	0-100	.	.		3	0	0-97	1	0	0-100				1	0	0-100	2	0	0-100			
ST ANTHONY HOSP HAYS KS 67601	7	14	3-64	3	67	9-90	21	5	4-35	1	0	0-100	74	5	2-15	68	3	1-15	15	0	0-97	51	2	1-15	30	3	0-22			
ST CATHERINE HOSP GARDEN CITY KS 67846	3	33	2-82	8	0	10-69	37	5	2-23	3	0	0-100	87	6	2-13	56	5	1-16	12	0	0-100	36	0	1-19	34	0	1-19			
ST FRANCIS HOSP AND MED CT TOPEKA KS 66606	29	21	6-43	18	44	19-63	70	14	3-18	4	0	0-100	199	6	3-10	132	2	1-11	28	0	0-47	256	4	2-8	191	1	0-5			
ST FRANCIS REGIONAL MEDICA WICHITA KS 67214	70	19	11-41	41	27	23-55	120	13	4-16	6	0	0-99	284	7	3-10	127	3	1-12	34	0	0-60	802	5	3-7	366	2	0-4			
ST JOHN DISTRICT HOSP SAINT JOHN KS 67576	.	.		1	100	3-99				.	.		10	10	0-47	3	0	0-95	.	.		6	17	0-66	4	0	0-100			
ST JOHN HOSP LEAVENWORTH KS 66048	1	0	0-98	6	17	10-76	13	0	1-40	2	0	0-100	37	3	1-19	29	0	0-25	3	0	0-100	12	8	0-42	16	0	0-46			
ST JOHNS HOSP SALINA KS 67401	6	0	4-69	3	0	2-82	33	3	4-28	170	0	0-4	84	7	2-14	48	0	0-19	14	0	0-69	33	6	1-21	99	0	0-8			
ST JOSEPH HOSP CONCORDIA KS 66901	4	25	5-80	7	14	10-73	11	0	2-45	11	0	0-100	63	2	3-17	45	0	2-20	2	0	0-100	45	9	1-17	16	0	0-36			
ST JOSEPH MED CTR WICHITA KS 67218	25	28	9-48	26	27	19-57	75	9	4-18	39	0	0-34	207	3	3-10	75	3	1-15	26	0	0-87	303	7	3-8	139	1	0-6			
ST JOSEPH MEM HOSP LARNED KS 67550	2	50	2-91	1	0	1-97	2	0	0-87	.	.		14	0	0-41	2	0	0-100	.	.		5	0	0-71	1	0	0-100			
ST LUKES HOSP MARION KS 66861	3	0	1-82	.	.		7	0	0-60	.	.		28	7	1-23	11	0	0-46	2	0	0-100	16	0	0-34	15	7	0-45			
ST LUKES HOSP WELLINGTON KS 67152	5	0	7-77	3	0	7-88	7	0	1-58	.	.		61	8	2-15	14	0	1-38	3	0	0-100	31	6	1-21	20	0	0-56			
ST MARYS HOSP MANHATTAN KS 66502	.	.		11	9	11-63	40	8	3-24	23	0	0-86	68	3	2-15	35	3	1-21	14	0	0-100	42	5	1-18	66	0	0-11			
ST MARYS HOSPITAL EMPORIA KS 66801	1	100	0-97	3	33	7-89	15	7	1-37				49	0	1-15	18	6	0-36	1	0	0-100	22	5	1-26	23	0	0-32			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																									
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
STAFFORD DIST HOSP 4 STAFFORD KS 67578	KS-143*	196	15	10-21	4	25	3-77	4	50	4-77	7	14	5-65	15	33	10-53	13	23	22-72				20	20	9-46
STANTON CO HOSP JOHNSON KS 67855	KS-144	36	11	6-31	.	.	.	.	.	.	.	.	.	3	33	2-82	1	100	2-98	2	0	0-90	8	25	5-60
STEVENS CO HOSP HUGOTON KS 67951	KS-145	72	11	6-23	5	20	6-75	2	50	1-89	1	100	1-97	3	67	3-82	4	25	7-82	1	0	0-97	4	25	5-79
STORMONT VAIL REG MED CTR TOPEKA KS 66606	KS-146	2646	9	7-13	184	16	14-30	97	22	18-37	44	16	9-34	135	24	15-30	89	28	28-49	31	13	5-35	143	20	14-29
TREGO CO-LEMKE MEM HOSP WAKEENEY KS 67672	KS-147*	189	10	8-20	9	56	13-71	14	29	11-56	4	0	1-75	3	33	7-88	2	0	3-91	16	6	3-41	22	14	8-43
UNIV OF KANSAS MED CTR KANSAS CITY KS 66103	KS-148*	2215	10	8-15	239	15	20-36	38	29	15-43	48	13	11-36	63	11	13-34	50	38	26-53	41	22	11-39	110	17	13-30
WAMEGO CITY HOSP WAMEGO KS 66547	KS-149	119	19	11-26	4	75	4-77	8	38	9-67	3	0	0-83	10	30	7-58	9	56	20-78	6	17	1-63	20	20	10-47
WASHINGTON CO DISTRICT 1 H HANOVER KS 66945	KS-150*	75	19	10-28	3	0	2-82	2	0	2-90	1	0	0-99	4	0	3-75	7	43	14-77	.	.	.	13	23	6-50
WASHINGTON CO HOSP WASHINGTON KS 66968	KS-151*	137	20	9-22	2	0	1-89	5	40	7-76	7	14	3-61	4	50	6-80	7	57	14-77	.	.	.	29	31	11-42
WELLINGTON HOSP AND CLINIC WELLINGTON KS 67152	KS-152	177	16	9-20	5	60	6-76	6	33	8-72	6	17	1-63	11	0	6-54	13	38	16-65	3	0	1-81	27	26	7-37
WESLEY MEDICAL CTR WICHITA KS 67214	KS-153*	3686	10	8-14	286	21	18-34	111	26	19-37	69	14	8-28	145	22	17-32	139	32	27-45	97	23	10-30	183	21	12-26
WICHITA COUNTY HOSPITAL LEOTI KS 67861	KS-154*	37	11	5-27	.	.	.	3	0	4-84	.	.	.	.	.	.	1	100	1-97	2	50	2-90	8	13	3-57
WILSON BOB MEM GRANT CO HO ULYSSES KS 67880	KS-155	174	13	7-18	4	75	10-86	7	43	8-69	4	25	1-74	14	21	5-46	4	25	8-83	4	0	0-77	24	8	5-36
WILSON CO HOSP NEODESHA KS 66757	KS-156	140	22	11-25	9	44	8-63	6	67	11-77	6	17	2-64	7	29	4-62	6	67	16-83	4	0	1-74	19	26	7-44

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
STAFFORD OIST HOSP 4 STAFFORD KS 67578	2	0	1-90	7	43	9-71	1	100	0-100	.	.		19	5	0-31	3	0	0-98	1	0	0-100	22	14	1-26	1	0	0-100			
STANTON CO HOSP JOHNSON KS 67855	3	0	1-82	.	.		1	0	0-100	.			1	0	0-100	1	0	2-98	1	0	0-100	4	0	0-81	2	0	0-100			
STEVENS CO HOSP HUGOTON KS 67951	2	0	1-90	.	.					1	0	0-100	15	0	0-37	2	0	0-92				6	17	0-64	6	0	0-100			
STORMONT VAIL REG MED CTR TOPEKA KS 66606	13	38	7-57	10	30	13-68	120	18	5-17	30	0	0-71	206	4	2-9	162	2	1-11	36	0	0-81	316	4	3-8	252	1	0-5			
TREGO CO-LEMKE MEM HOSP WAKEENEY KS 67672		.		4	25	4-78	1	0	0-98				10	20	1-46	6	17	0-64	1	0	0-100	16	0	1-33	6	0	0-100			
UNIV OF KANSAS MED CTR KANSAS CITY KS 66103	39	15	7-41	28	64	25-64	39	18	3-24	19	0	0-81	135	4	3-12	130	2	1-12	51	0	0-13	152	7	2-9	139	1	0-6			
WAMEGO CITY HOSP WAMEGO KS 66547	1	100	2-98	.	.		1	0	0-98				13	8	1-39							4	25	0-84	6	0	0-78			
WASHINGTON CO OISTRICT 1 H HANOVER KS 66945	2	0	4-93	4	0	5-79					.		4	0	0-94	4	0	0-75	3	0	0-100	3	0	0-90	2	0	0-100			
WASHINGTON CO HOSP WASHINGTON KS 66968	1	0	0-98	.	.		4	0	0-75	.	.		29	3	1-22	7	0	0-63	.	.		3	33	0-93	5	0	0-81			
WELLINGTON HOSP AND CLINIC WELLINGTON KS 67152	2	100	5-94	5	20	10-81	.	.		.			20	15	0-29	22	0	0-29	3	0	0-100	14	7	0-37	7	0	0-95			
WESLEY MEDICAL CTR WICHITA KS 67214	21	29	10-53	25	52	25-64	99	11	4-17	147	0	0-6	245	4	2-9	146	3	2-12	56	0	0-60	397	5	3-8	367	1	1-4			
WICHITA COUNTY HOSPITAL LEOTI KS 67861	.	.		.	.					.	.		6	0	0-72	1	0	0-99	1	0	0-100	6	0	0-70	2	0	0-99			
WILSON BOB MEM GRANT CO HO ULYSSES KS 67880	4	50	2-77	2	100	3-91	2	0	0-97				26	4	1-24	2	0	0-95	1	0	0-100	22	5	1-27	7	0	0-96			
WILSON CO HOSP NEODESHA KS 66757	2	50	5-94	5	100	10-80	9	11	1-50				22	5	2-29	1	0	0-100	1	0	0-100	3	0	0-83	5	0	0-96			

*Written Comments Not Submitted

Allen County Hospital, Inc.

October 26, 1987

COMMENTS ON HCFA MORTALITY DATA

Allen County Hospital
Medicare Provider Number: 170116

Data Verification

The data used by HCFA indicate that a total of 78 Medicare patients admitted to Allen County Hospital during 1986 died within 30 days of admission, either while hospitalized or after discharge from the hospital. Fifty-five patients died while still in the hospital, while 23 died after discharge. It is impossible to verify the number of the patients who died after discharge as information concerning death after discharge is not included in the patient's medical records. The average age of the patients who died was 81.1 years.

Interpretive Remarks

Allen County Hospital is pleased to see that our mortality rates for Medicare patients for 1986 are within the normal range of predicted mortality rates as determined by HCFA. We do feel, however, that under no circumstances should they be used as a basis for judging the quality of care provided at our facility.

The HCFA statistics may accurately and reliably reflect the relationship between a small number of patient characteristics and the risk of death, but it does not reliably predict hospital mortality rates. The data fail to consider a wide range of factors with a significant impact on mortality; such as age, severity of illness, stage of illness, health status, available family support and the patient's own desires to not be kept alive by artificial means. Because of these limitations, we feel the statistics may not accurately reflect the care provided at our hospital.

Results of Medical Record Review

As part of our Quality Assurance Program, our medical staff routinely reviews all deaths which occur at our institution to determine if there are any questions regarding quality of medical care. All cases included in our statistics have been reviewed under this process.

Providing quality care is of uppermost concern to the governing body, administration, and the medical staff at our facility. We have an active quality assurance program and routinely monitor the quality of care provided at our institution through mortality review as well as numerous other processes.

101 South First | Box 540 | Iola, Kansas 66749 | 316-365-3131

SUSAN B. ALLEN
MEMORIAL HOSPITAL

720 WEST CENTRAL AVENUE
EL DORADO, KANSAS 67042
(316) 321-3300

October 28, 1987

This is in response to the expectation that HCFA will be releasing to the general public hospital-specific 1986 Medicare mortality data.

The base figure that HCFA used for the Susan B. Allen Memorial Hospital was 591 Medicare cases even though our Hospital records show that we had 1023 Medicare admissions in 1986. The data used by HCFA indicate that a total of 59 Medicare patients admitted to Susan B. Allen Memorial Hospital died within 30 days of admission. Of these, 49 died while still a patient in the hospital and 10 died after discharge.

In all of HCFA's sixteen diagnostic categories, Susan B. Allen Memorial Hospital's mortality rate falls inside of HCFA's range of predicted mortality rate.

I personally recognize that consumers have a legitimate interest in useful, reliable information on the quality of care that is available to them. However, my major criticism of the HCFA data is that their mortality rates, by themselves, do not measure quality. Quality can only be evaluated through the process of peer review and not through simplistic statistical comparisons. Mortality data, like HCFA's, are most appropriately used to guide or focus peer review and quality judgments can only be made after review of information contained in the patient's medical record.

Because mortality data are easily misinterpreted, they can cause confusion and apprehension among Medicare beneficiaries and the public in general.

Quality of care is of the utmost concern to Susan B. Allen Memorial Hospital's governing board, management, employee staff, and medical staff. The Hospital utilizes a very comprehensive quality assurance program to monitor and evaluate the quality and appropriateness of care provided to its patients. When quality problems are identified, corrective action is swiftly taken. A review of hospital deaths is a part of our Hospital's quality assurance program.

I would like to repeat that HCFA's mortality data do not identify areas in which a hospital provides "high quality" or "low quality" care nor does it otherwise measure hospital performance.

HCFA's model for calculating mortality rates fails to consider a wide range of factors which have a significant impact on mortality. Many of these factors are beyond a hospital's control, but they still affect patient outcome and "hospital performance". The severity of the patient's illness and the patient's socioeconomic factors aren't considered in HCFA's calculations. The data do not take into account if a patient's death was anticipated or planned. The data reflect deaths that occur outside of the hospital as well as inside. Death can occur outside of the hospital as a result of mismanagement of care in the person's home or in a nursing home and as a result of a car accident - and still the statistic is attributed to the hospital's mortality rate by the HCFA model.

In summary, HCFA's data are not, in themselves, measures of hospital performance. At best, the data can be used by hospitals to better focus their own quality assurance activities. The data, as it is, should never be used as a basis for judging the quality of care provided by different hospitals.

Jim Wilson
Administrator

JW:bjc

ARKANSAS CITY MEMORIAL HOSPITAL

October 26, 1987

Department of Health
and Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: HCFA Mortality Data
HPN: 17-0150

Dear Sirs:

After a thorough review of data provided by your department it is our opinion that there exist significant errors which render your report invalid. This institution was reported to be outside of the, "Range of Predicted Mortality Rates" for the category shown as "HS" Severe Acute Heart Disease. While we take exception to many aspects of this reporting model we believe it essential to at least have a true and accurate recording of case data.

When your September 21, 1987 notification letter was received and this organization discovered that it had "fallen out" of a particular high risk group we immediately began review and analysis of the data provided by your office. According to your report, this hospital is shown to have a total of thirteen (13) "HS" cases of which nine (9) were reported deaths. This equates to a 69% mortality rate. The established hospital specific parameters for this organization, in this category, is 18-68%.

A review of this institution's mortality data indicates that there were a total of twenty-two (22) cases reported within the Severe Acute Heart Disease category within the 1986 calendar year. We applied the same criteria as outlined in your transmittal letter, each of the twenty-two (22) cases were identified as their last 1986 admission, submitted within the routine process of billing with the appropriate coding indices. I have provided a listing similar to the one provided by your office identifying all the above cited data. Of these twenty-two (22) cases, we have identified eleven (11) as having expired. The mortality cases have been reviewed extensively and verified that final submission of the billing data corresponded with the "HS" category. Utilizing our verifiable data our mortality rate for this specific category would be 50%. Because of the complexity of your model we were unable to determine whether or not the "acceptable" performance ranges would change because of the greater incidence. We have assumed that it would not, and therefore the institution's mortality rates all fall within your presumed "acceptable" parameters.

216 West Birch • Arkansas City, Kansas 67005 • (316) 442-2500

In addition to the above cited specific concerns we share a similar concern with the majority of other AHA member hospitals. The mortality model, as currently used, does not adequately measure mortality. I understand and accept the purpose of desiring to "better inform" the consumers, however it is my belief that the community reliance of this less than accurate gauge will only create additional confusion as to the true, important factor the public desires--that being quality. While it is stated that this report and data is not meant to be a complete measure of quality of care at an individual hospital, it will more than likely be perceived as just that.

As I am sure you are aware hospitals throughout this nation employ extraordinary measures to insure that quality medicine is practiced at their facilities. One positive point of your mortality report is that it will require hospitals to improve their community communication to the public as to those specific quality measures. While I commend you for your lofty efforts of endeavoring to better inform the public, I personally believe that the overall project is of a much larger magnitude and presents a real and serious threat to the public's confidence in its health care system. Prematurely publishing reports and data that make generalized statements will only tend to confuse the public.

The mortality model used does not measure quality, as you state, but in my evaluation only serves to measure relationships between hospital associated mortality and a selected group of patient characteristics, with only a minimum consideration given to patient morbidity. This report only represents the average mortality rate that would be experienced by hospitals treating patients similar to those admitted to our hospital. Therefore the "predicted" mortality rate can be interpreted either as the mortality rate that would be experienced by the "average" hospital if it admitted the same mix of patients as the hospital in question, or as the mortality rate that would be experienced by the hospital if its mortality rate was "average".

In both cases, the model implicitly assumes that within a given sub-category (HS), the hospital's patients are "average"--neither more or less severely ill, neither healthier nor less healthy than average, etc.. I do not believe that is an assumption that can be readily accepted within our industry.

Concerning the mentioned inaccuranies of our report, I would welcome your review of the provided data and confirmation of its validity. Additionally, I would appreciate a recomputation of our report should the provided data prove to be accurate.

Sincerely,

Ralph F. Paulding
Chief Executive Officer

CC: AHA
KHA

SUMMARY:

		HCFA
TOTAL NUMBER OF 1986 ADMISSIONS FOR IN HS CATEGORY:	32	13*
TOTAL NUMBER OF PATIENTS WITH LAST ADM. IN HS CATEGORY:	22	13
TOTAL NUMBER OF PATIENTS EXPIRED WITHIN 30 DAYS OF LAST ADMISSION:	11	9**
PERCENTAGE (EXPIRED OF TOTAL):	50.00%	69.23%
AVERAGE AGE OF HS CATEGORY PATIENT:	75.7 YEARS	
AVERAGE AGE OF HS CATEGORY PATIENT WHO EXPIRED:	78.4 YEARS	

*HCFA STATISTICS INCLUDE ONLY LAST ADMISSION
**HCFA STATISTICS APPARENTLY DO NOT INCLUDE TWO DEATHS
WHICH WERE IN ST. FRANCIS HOSPITAL OVER 24 HOURS

1986- ACMH STATISTICS

TOTAL NUMBER MEDICARE PATIENTS:		957
NUMBER MEDICARE PATIENTS - EXPIRED		65
NUMBER OF SWINGBED PATIENTS EXPIRED		1
	TOTAL	66
PERCENTAGE MEDICARE PTS/EXPIRED		6.9%

TOTAL NUMBER MEDICARE PATIENTS EXPIRED (HCFA)		78
HCFA PATIENTS EXPIRED - OUT OF HOSPITAL		13
HCFA PATIENTS EXPIRED-SWINGBED		1
NUMBER MEDICARE PATIENTS EXPIRED -IH-(HCFA)		64
MEDICARE PATIENT EXPIRED NOT ON HCFA LIST		1
	TOTAL-IH	66

MEDICARE DISMISSALS FOR 1986
SPECIFIC HCFA USED CODES - SEVERE ACUTE HEART DISEASE (HS)
ALL MEDICARE ADMISSIONS WITHIN HS CATEGORY

	PATIENT ID NUMBER (HIC) NAME	DIAG. CAT.	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	EXPIRED WITHIN 30 DAYS OF LAST ADM.	STILL LIVING	ON HCFA LIST	RECORD NUMBER	PRINC. DIAG.	LAST 86 ADMISSION	PRIOR ADM. WITHIN 60 DAYS	LENGTH OF STAY (DAYS)
1		HS	67	F	2/4/86	2/14/86	NO	YES	NO	4649	410.1	NO	NONE	10
2		HS	66	F	11/6/86	11/17/86	NO	YES	NO	191	410.8	YES	NONE	11
3		HS	67	F	5/17/86	5/19/86	NO	YES	NO	4649	410.1	YES	YES	2
4		HS	75	M	9/3/86	9/15/86	NO	YES	NO	1189	410.1	YES	NONE	12
5		HS	75	M	3/14/86	3/24/86	NO	YES	NO	4820	410.7	YES	NONE	10
6		HS	67	M	10/4/86	10/16/86	NO	YES	NO	5630	410.3	YES	NONE	12
7		HS	82	F	5/27/86	6/3/86	NO	YES	NO	5113	410.7	NO	NONE	7
8		HS	71	M	5/11/86	5/15/86	NO	YES	NO	5054	410.4	YES	NONE	4
9		HS	75	M	12/11/86	12/12/86	NO	YES	NO	5851	410.4	YES	NONE	1
10		HS	86	F	5/15/86	5/20/86	NO	YES	NO	2299	410.1	NO	NONE	5
11		HS	75	M	1/20/86	1/23/86	NO	YES	NO	4592	410.9	YES	NONE	3
12		HS	77	M	12/6/86	12/15/86	NO	YES	NO	2544	410.4	NO	YES	9
13		HS	70	M	7/12/86	7/15/86	NO	NO	NO	3072	410.4	NO	NONE	3
14		HS	66	M	10/12/86	10/13/86	NO	YES	NO	5652	410.2	YES	NONE	1
15		HS	70	F	5/20/86	5/28/86	NO	YES	NO	5097	410.0	YES	NONE	8
16		HS	50	M	6/11/86	6/12/86	NO	YES	NO	5178	410.4	YES	NONE	1
17		HS	86	F	5/22/86	5/30/86	NO	YES	NO	2299	410.1	NO	YES	8
18		HS	84	F	3/21/86	4/1/86	NO	YES	NO	1365	410.1	NO	NONE	11
19		HS	87	M	7/8/86	7/12/86	YES-1987-	NO	NO	5282	410.7	NO	NONE	4
20		HS	78	M	10/17/86	10/24/86	YES-1987-N	NOS	NO	5627	410.4	NO	YES	7
21		HS	86	M	6/27/86	7/3/86	YES-1987-N	NOS	NO	2171	410.1	NO	NONE	6
22		HS	83	M	5/12/86	5/19/86	YES-IH	NO	YES	1531	410.1	YES	NONE	7
23		HS	81	F	8/30/86	9/1/86	YES-IH	NO	YES	5496	410.4	YES	NONE	2
24		HS	72	M	6/2/86	6/5/86	YES-IH	NO	YES	5144	410.4	YES	NONE	3
25		HS	93	M	2/16/86	2/17/86	YES-IH	NO	YES	4173	410.0	YES	NONE	1
26		HS	85	M	7/31/86	8/1/86	YES-IH	NO	YES	667	427.5	YES	NONE	1
27		HS	70	M	8/8/86	8/9/86	YES-IH	NO	YES	3072	427.5	YES	YES	1
28		HS	67	F	9/25/86	9/26/86	YES-IH	NO	YES	1533	427.5	YES	YES	1
29		HS	91	F	7/19/86	7/24/86	YES-IH	NO	YES	1656	410.1	YES	NONE	5
30		HS	70	M	10/6/86	10/6/86	YES-OH-SF	NO	YES	3696	785.51	YES	YES	1
31		HS	71	M	10/7/86	10/8/86	YES-OH-SF	NO	NO	5486	410.8	YES	YES-2	1
32		HS	79	F	7/18/86	7/21/86	YES-OH-SF	NO	NO	5324	410.4	YES	NONE	3
	TOTALS						NO-18 YES-IH-8 YES-OH-3 YES-1987-HS-1 YES-1987-2	NO-15 YES-17	NO-23 YES-9			NO-10 YES-22	YES-8 NO-24	161 AVERAGE LOS-5 DA

LEGEND: HS - HCFA'S CODE FOR SEVERE ACUTE HEART DISEASE
IH - INHOSPITAL DEATH
OH - OUT OF HOSPITAL DEATH
SL - STILL LIVING
SF - ST. FRANCIS HOSPITAL,WICHITA, KANSAS

MEDICARE DISMISSALS FOR 1986
SPECIFIC HCFA USED CODES - SEVERE ACUTE HEART DISEASE (HS)
LAST 1986 MEDICARE ADMISSION PER PATIENT

	PATIENT ID NUMBER (HIC)	NAME	DIAG. CAT.	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	EXPIRED WITHIN 30 DAYS OF LAST ADM.	STILL LIVING	ON HCFA LIST	RECORD	PRINC. DIAG.	LAST 86 ADMISSION	PRIOR ADM WITHIN 60 DAYS	LENGTH OF STAY (DAYS)
1	[redacted]		HS	75	M	1/20/86	1/23/86	NO	YES	NO	4592	410.9	YES	NONE	3
2			HS	67	F	5/17/86	5/19/86	NO	YES	NO	4649	410.1	YES	YES	2
3			HS	75	M	3/14/86	3/24/86	NO	YES	NO	4820	410.7	YES	NONE	10
4			HS	75	M	12/11/86	12/12/86	NO	YES	NO	5851	410.4	YES	NONE	1
5			HS	50	M	6/11/86	6/12/86	NO	YES	NO	5178	410.4	YES	NONE	1
6			HS	66	M	10/12/86	10/13/86	NO	YES	NO	5652	410.2	YES	NONE	1
7			HS	75	M	9/3/86	9/15/86	NO	YES	NO	1189	410.1	YES	NONE	12
8			HS	70	F	5/20/86	5/28/86	NO	YES	NO	5097	410.0	YES	NONE	8
9			HS	71	M	3/11/86	5/15/86	NO	YES	NO	5054	410.4	YES	NONE	4
10			HS	66	F	11/6/86	11/17/86	NO	YES	NO	191	410.8	YES	NONE	11
11			HS	67	M	10/4/86	10/16/86	NO	YES	NO	5630	410.3	YES	NONE	12
12			HS	91	F	7/19/86	7/24/86	YES-IH	NO	YES	1656	410.1	YES	NONE	5
13			HS	72	M	6/2/86	6/5/86	YES-IH	NO	YES	5144	410.4	YES	NONE	3
14			HS	70	M	8/8/86	8/9/86	YES-IH	NO	YES	3072	427.5	YES	YES	1
15			HS	81	F	8/30/86	9/1/86	YES-IH	NO	YES	5496	410.4	YES	NONE	2
16			HS	93	M	2/16/86	2/17/86	YES-IH	NO	YES	4173	410.0	YES	NONE	1
17			HS	85	M	7/31/86	8/1/86	YES-IH	NO	YES	667	427.5	YES	NONE	1
18			HS	67	F	9/25/86	9/26/86	YES-IH	NO	YES	1533	427.5	YES	YES	1
19			HS	83	M	5/12/86	5/19/86	YES-IH	NO	YES	1531	410.1	YES	NONE	7
20			HS	71	M	10/7/86	10/8/86	YES-OH-SF	NO	NO	5486	410.8	YES	YES-2	1
21			HS	79	F	7/18/86	7/21/86	YES-OH-SF	NO	NO	5324	410.4	YES	NONE	3
22			HS	70	M	10/6/86	10/6/86	YES-OH-SF	NO	YES	3696	785.51	YES	YES	1
	TOTALS							NO-11 YES-IH-8 YES-OH-3	NO-11 YES-11	NO-13 YES-9			YES-22	YES-8 NO-24	91 AVERAGE LOS-5 DAYS

LEGEND: HS - HCFA'S CODE FOR SEVERE ACUTE HEART DISEASE
IH - INHOSPITAL DEATH
OH - OUT OF HOSPITAL DEATH
SL - STILL LIVING
SF - ST. FRANCIS HOSPITAL,WICHITA, KANSAS

MEDICARE DISMISSALS FOR 1986
SPECIFIC HCFA USED CODES - SEVERE ACUTE HEART DISEASE (HS)
1986 MEDICARE HS DEATHS

	PATIENT ID NUMBER (HIC)	NAME	DIAG. CAT.	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	EXPIRED WITHIN 30 DAYS OF LAST ADM.	ON HCFA LIST	RECORD	PRINCIPLE DIAGNOSIS	LAST 86 ADMISSION	PRIOR ADM. WITHIN 60 DAYS	LENGTH OF STAY (DAYS)
1	[redacted]		HS	91	F	7/19/86	7/24/86	YES-IH	YES	1656	410.1	YES	NONE	5
2			HS	72	M	6/2/86	6/5/86	YES-IH	YES	5144	410.4	YES	NONE	3
3			HS	70	M	8/8/86	8/9/86	YES-IH	YES	3072	427.5	YES	YES	1
4			HS	81	F	8/30/86	9/1/86	YES-IH	YES	5496	410.4	YES	NONE	2
5			HS	93	M	2/16/86	2/17/86	YES-IH	YES	4173	410.0	YES	NONE	1
6			HS	85	M	7/31/86	8/1/86	YES-IH	YES	667	427.5	YES	NONE	1
7			HS	67	F	9/25/86	9/26/86	YES-IH	YES	1533	427.5	YES	YES	1
8			HS	83	M	5/12/86	5/19/86	YES-IH	YES	1531	410.1	YES	NONE	7
9			HS	71	M	10/7/86	10/8/86	YES-OH-SF	NO	5486	410.8	YES	YES-2	1
10			HS	79	F	7/10/86	7/21/86	YES-OH-SF	NO	5324	410.4	YES	NONE	3
11			HS	70	M	10/6/86	10/6/86	YES-OH-SF	YES	3696	785.51	YES	YES	1
	TOTALS							YES-IH-8 YES-OH-3 TOTAL -11	NO-2 YES-9			YES-11	YES-4 NO-7	26 AVERAGE LOS-2.4 DAYS

LEGEND: HS - HCFA'S CODE FOR SEVERE ACUTE HEART DISEASE
IH - INHOSPITAL DEATH
OH - OUT OF HOSPITAL DEATH
SL - STILL LIVING
SF - ST. FRANCIS HOSPITAL,WICHITA, KANSAS

SUMMARY:

		HCFA
TOTAL NUMBER OF 1986 ADMISSIONS FOR IN HS CATEGORY:	32	13*
TOTAL NUMBER OF PATIENTS WITH LAST ADM. IN HS CATEGORY:	22	13
TOTAL NUMBER OF PATIENTS EXPIRED WITHIN 30 DAYS OF LAST AD	11	9**
PERCENTAGE (EXPIRED OF TOTAL):	50.00%	69.23%
AVERAGE AGE OF HS CATEGORY PATIENT(LAST ADMISSION):	73.6 YEARS	
AVERAGE AGE OF HS CATEGORY PATIENT WHO EXPIRED:	78.4 YEARS	

AGE RANGE:	
67 - 69	1
70 - 74	4
75 - 79	1
80 - 84	2
85 - 89	1
90+	2
TOTAL	11

*HCFA STATISTICS INCLUDE ONLY LAST ADMISSION
**HCFA STATISTICS APPARENTLY DO NOT INCLUDE TWO DEATHS
WHICH WERE IN ST. FRANCIS HOSPITAL OVER 24 HOURS

ASBURY HOSPITAL

400 S SANTA FE / SALINA, KANSAS 67401 / (913) 827-4411

October 22, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

NOTE: Asbury Hospital, Salina, Kansas
Mortality Data Response
Provider Number: 170012

Dear Dr. Roper:

We sincerely appreciate the opportunity to comment on the 1986 mortality data, for Medicare patients only, as presented by the Health Care Financing Administration (HCFA). Our review of the mortality data indicates no errors in the admission or discharge dates. We do not have data to verify deaths that have occurred after discharge and outside the hospital.

Asbury Hospital has demonstrated a record that is well within the "range of predicted mortality rates" as determined by HCFA. The hospital and its medical staff are committed to a comprehensive quality monitoring program, which includes mortality data.

As a designated "Rural Referral Center" by HCFA, our hospital has sicker patients, with more complex diagnoses, from a large rural service area. This is evident from our high case-mix index, as recognized by HCFA as the measurement of intensity of service and severity of illness.

The data demonstrates that the average age for the patients listed was 78 years. More than sixty percent were well beyond the age of the average life expectancy in the United States.

Asbury Hospital is proud of the quality of care provided to our patients and is dedicated to the continuation of excellence in health care.

Sincerely,

Clay D. Edmands
President

/jr

Hazel Thomas,
Administrator

Ashland District Hospital

709 Oak Street

Ashland, Kansas
67831

September 24, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

In regard to the mortality statistics recently sent to our facility we feel we need to point out the inaccuracies.

Regarding patient [redacted] age 89, if you check the records you will see that that patient was admitted to our facility on 3-18-86 and discharged to Fountain View Villa nursing home on 3-29-86. He did not expire in our facility and we would appreciate knowing why you reported it as such.

Regarding patient [redacted] age 80, we hardly think it fair that you show a mortality rate of 100% for the GI diagnosis as this was the only patient we had with that diagnosis in 1986. Taking the facts from his medical record it also shows the patient had undergone the removal of a malignant right ureter less than six months in the Humana Hospital, Dodge City, Kansas, prior to his admission in our facility. The patient's medical history also listed anorexia and numerous other medical diagnoses.

Regarding patient [redacted] age 79, the medical records show that this patient had experienced an inferolateral myocardial infarction with cardiac arrest approximately three weeks prior to her admission in our facility on 6-17-86. There were other circumstances related to this patient also.

Regarding patient [redacted] age 75, this patient had sustained a fracture of the left hip and had surgery in Humana Hospital, Dodge City, Kansas, just three weeks prior and had suffered cardiac arrest while in surgery requiring her a week in intensive care in that facility before being transferred to the Fountain View Villa Nursing Home. Upon admission to our facility, 10-09-86, the medical records show that this patient also had a history of hypertension and malnutrition

which certainly complicates the severe chronic heart diease that she succumbed to.

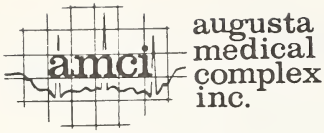
The point we are trying to make is that when your figures are printed for the public it does not relate these other circumstances and it leaves the hospital wide open for a great deal of criticism which, at this particular time, can be very damaging. We are already bombarded with resentment on all the forms and paperwork it takes for a patient to become an inpatient, as well as trying to explain the DRGs and why Medicare does not pay for longer hospitalizations.

We very much appreciate your hearing us out on these issues and do hope printed reports in the future can be not so incriminating.

Sincerely,

Hazel Thomas

Hazel Thomas, Administrator
HT/sab



October 27, 1987

Health Care Financing Administration
Health Status & Quality Bureau
Hospital Mortality Information
6300 Security Blvd., Rm. D-2, Meadows East
Baltimore, Md. 21207

Regarding: Hospital Medicare Provider #17-0171

Dear Mr. Harvey Brook:

Our Hospital wishes to respond to your September 21, 1987 memo including our report regarding our Hospital's statistics on Mortality information on Medicare patients discharged in 1986, where death occurred within thrity days after discharge.

All cases identified on your report were pulled and reviewed by their Attending Physicians. A lengthy discussion was held by our Medical Staff at their monthly meeting. Our Physicians failed to find any validity to this study. All Attending Physicians reported they found no cases in this list that contained any unexpected deaths with the exception of one. This case had an autopsy performed.

Our Hospital is located within 15 minutes of a S.M.S.A. Major City which allows our Hospital immediate access to all Specialists in this City. Therefore, our Active Admitting Staff had the support of 27 Consulting Physicians on our Medical Staff. Our total Medical Staff Membership during 1986 was 63 members. This availability of highly qualified Specialists who will come to our Facility for Consulting and Active treatment of patients would probably allow our 40 bed Hospital to keep and treat patients that are routinely transferred by other small hospitals of comparable size.

We found it interesting to note that our report reflects all fifteen Diagnostic Categories are within Range of Predicted Mortality Rates. We seriously question any significance to these statistics. For example, of the 15 Diagnostic Categories, 67% of these categories have total involvement of ten cases or fewer. Only 2 categories have 25 or more cases involved. While any death is significant and should be reviewed and considered, we had only 5 categories that had more than two deaths in them. Your data is based on 243 discharged cases, while our Medicare dismissals for the year was 391.

2101 Dearborn · P.O. Box 430 · Augusta, Kansas 67010 · 316-775-5421

In reviewing our report, we get the impression that your statistics are based on the DRG assigned to the case. In many cases, the cause of death is not necessarily the same as the reason for hospitalization. It is our concern that you truly have apples and oranges for comparison. Without the methodiology utilized in this study, we can not be sure what you are comparing.

Our Hospital has a Risk Management and Quality Assurance Plan that is being implemented in conformance with recent Kansas Statutes regarding these programs. The Board of Trustees, Medical Staff and all Employees support the progress and concepts as outlined and defined in this plan. Our Hospital is committed in providing the best quality of care that we are able to develop for our Community. We feel that the quality of care in the past has been reflective of this committment. We appreciate the opportunity to provide our comments to your Agency regarding this study.

Sincerely,

Larry D. Wilkerson
CEO

CC: Active Medical Staff Members
Board of Trustees

Axtell Christian Hospital 209 East Broadway/Newton, Kansas 67114/(316) 283-5200

October 26, 1987

Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P. O. Box 26676
Baltimore, Maryland 21201

RE: Comments: Medicare Program: Selected Performance Information on Hospitals Providing Care to Medicare Beneficiaries: HSQ-148-GNC

The Health Care Financing Admministration has established an initiative directed at improving the quality measurement of care provided Medicare beneficiaries, improving the methodologies used to analyze the data collected by HCFA and improving the distribution and application of understandable and useful information.

As a provider of hospital and medical services to Medicare beneficiaries the Axtell Christian Hospital recognizes the importance of understandable and useful health care information to the public. The provision of meaningful information is important to informed decision-making. As a hospital, we work with numerous agencies to provide information relating to the performance of our facility and the care provided, including HCFA, the American Hospital Association, the Kansas Hospital Association, the Kansas Foundation for Medical Care (Medicare's designated peer review organization in Kansas), the State of Kansas, Blue Cross/Blue Shield (Medicare's intermediary in Kansas), private insurances, the Joint Commission on the Accreditation of Hospitals and others. Through these relationships and various programs, the Hospital maintains various activities in order to monitor and evaluate the appropriateness and quality of services provided.

Our hospital's comments are not an objection to the release of mortality data by HCFA but are meant to address the usefulness and the understandability and possible misinterpretation of such information which

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may occur through simplistic statistical comparisons. As a provider, we appreciate the opportunity to comment on the 1986 mortality data and to contribute to the direction of HCFA's initiatives on Medicare information.

In the review of our data, we found the raw data to be correct with the exception of two instances in which dates were incorrect causing one death to be reported following discharge instead of during hospitalization. No other errors in the data were uncovered.

With forty-seven (47) deaths reported during 1986, we have a very small sample from which to evaluate the significance of the information. As this data is further distributed across the sixteen (16) categories outlined, the statistical significance of the mortality rates are reduced and the predicted range's usefulness becomes extremely limited as is indicated by ranges that included 0% and 100% as lows and highs. Such ranges are some of the limitations of the data which should be recognized prior to interpretation.

Other limitations in the reliability of the model and methodology have been acknowledged by HCFA. The model presents a small number of patient characteristics and risks of death which have yet to be proven as statistically significant in explaining the differences in mortality rates and the deviations of the actual mortality rates and the predicted rates. Other characteristics such as the patients' general health status, stage of illness, psychological condition, pre-hospital care and family support may offer additional statistically significant information.

The statistical techniques used in presenting the data assures a percentage of all cases will be beyond the predicted values either on the high or low side just because of the techniques used. This will be true whether additional significant characteristics are included. This is especially significant to institutions with small numbers of cases being reported such as Axtell Christian Hospital since a small change in number of deaths within a category will affect the percentages radically.

The data presented could also be adjusted to recognize regional differences in information such as age since the national data set used differs from Kansas which has a significantly higher elderly population.

The Axtell Christian Hospital participates in ongoing utilization review, discharge planning and quality review programs for all patients receiving services and feels quality judgments are better made through a process of peer review which incorporates all available medical and statistical information. Reviewing these cases with regard to this type of review, we found 70% of all the cases included a do-not-resuscitate order in their medical chart revealing many of these patients were in the terminal phases of their disease and illness and were expected deaths. Of the ten deaths occurring after dismissal but within 30 days of admission, all of these

deaths were expected at the time of discharge and the patients were discharged home with family support or to a nursing home as additional acute care was not needed.

All of the deaths reported were screened in a number of ways by the peer review organization in Kansas, by the Hospital's utilization review program and through the medical staff's mortality review process. These screens included concurrent and retrospective reviews of the record and additional information available. Through these processes and evaluations, concerns are identified which lead to investigation and prompt action when warranted.

The distribution of useful, understandable and complete data to providers and the public stengthens the system by helping all to more clearly understand the complexity of the healthcare delivery system. The publication of mortality data by HCFA provides needed information. It also presents difficulties because of the limitations of the data, and the presentation of mortality data in and of itself does not clearly reflect quality of care provided by the hospitals. When incorporated into a program of review with other information, much better measures of quality can be achieved which in turn are more useful and understandable.

It is our hope that by making these comments, HCFA is able to further its efforts in meeting its initiatives and, as a result, better measures of care will be developed for the public. The quality and appropriateness of patient care services provided by the Axtell Christian Hospital is our utmost concern. The opportunity to comment on HCFA's mortality data is welcome.

Sincerely,

Larry C. Emerson
Assistant Administrator

gw

Behavioral Medical Center
Parsons, Kansas

Provider Number: 17-0178

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

BETHANY · MEDICAL · CENTER

The Hospital of Choice

COMMENTS
HCFA MORTALITY DATA

Bethany Medical Center
Kansas City, Kansas
170148

Summary

Bethany Medical Center was within the range of predicted mortality rates for all of the 17 HCFA designated diagnostic classifications. The average age of Medicare patients who died at Bethany was 76. The overwhelming majority of patients were seriously ill according to our nationally recognized severity of illness classification system. These deaths were not unexpected. Of the patients who died, 50% were so critically ill that the patients and their families decided not to have extraordinary measures performed to prolong life. As a full service community hospital, Bethany Medical Center provides comprehensive care with specialized programs, cancer care, physical rehabilitation for chronic diseases, and cardiac treatment, including the world's first coronary care unit. Considering the severity of illness of our Medicare patients and the advanced levels of care provided by Bethany Medical Center, the HCFA data demonstrates the high quality of care given by the hospital and its medical staff.

Data Verification

The HCFA data includes all Medicare deaths occurring at Bethany in 1986, but their total cases statistic of 2,190 includes only the last admission of the year for Medicare beneficiaries, including those who died within 30 days of their last admission. The model does not include all Medicare patients hospitalized at Bethany during 1986, but does include all deaths occurring at the hospital. According to official hospital records, 3,658 Medicare patients were admitted to Bethany Medical Center in 1986.

The hospital record of each patient who expired according to HCFA was reviewed to verify the accuracy of the data. There were numerous errors in the HCFA data related to patient age. In addition, there were 14 errors related to incorrect dates of admission, discharge, or death for those patients who died while in the hospital. A copy of the case listing identifying those mistakes in the HCFA data base has been attached to these comments.

Further verification of the accuracy of the HCFA data base is impossible because the detailed billing data HCFA used to compile predicted mortality rates was not supplied to the hospital for confirmation and analysis.

Interpretive Remarks

We are supplying additional supplemental information which we believe will be useful to the public in interpreting this data. The HCFA data represent only Medicare patients, who because of their age, are at higher risk of death. The reliability of the HCFA model is limited. While it may reflect a relationship between the five selected patient characteristics and risk of death, it does not account for a wide range of factors which significantly impact mortality that are outside the control of the hospital. Such factors include the socioeconomic status of the patient and the care the patient receives in post discharge facilities which are not associated with the hospital. For Bethany, only six of the sixteen HCFA

51 North 12th Street Kansas City, Kansas 66102 (913) 281-8400
VHA, Member of Voluntary Hospitals of America, Inc.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

categories had more than 100 patients, the level generally accepted for the data to have any statistical significance for analysis and conclusion. Even for these numbers of patients, it must be remembered that the HCFA model includes only selected, but not all comorbidities which impact patient outcome. Due to the advanced age of our Medicare population, nearly all patients had multiple disease states, not just the principal diagnosis to which HCFA classified each case.

70% of the deaths occurred in categories considered at high risk. Those categories considered at "low risk" by HCFA have cases classified in them which are questionably "low risk". For example, there were five open heart surgery deaths reported by HCFA in the "low risk" heart disease data, a sophisticated procedure which is generally considered more risky than cataract removals which were also classified as "low risk".

Cases were classified by HCFA on the basis of principal diagnosis. The cause of death is not necessarily directly related to the classification of the case. For example, the single mortality reported for Bethany in the Orthopedic classification was admitted because of a pathological fracture which resulted from a spread of his cancer from the prostrate to the bone. The principal diagnosis of fracture classified him to Orthopedics instead of to the Cancer category although the actual cause of death was due to the extensive cancer and not due to the fracture.

The severity of a patient's illness is not accounted for by the model. To do so requires the application of a severity of illness classification system to each case. Bethany Medical Center has a nationally recognized system in place to evaluate each patient's severity. A review of the severity of illness of the patients who died at Bethany confirms that those patients were severely ill and that death was an expected outcome or a significant possibility at the time of the admission. Of those deaths occurring after discharge, 39% were discharged to nursing homes for care during their terminal phases where death subsequently occurred.

Unique Hospital Characteristics

Established in 1892, Bethany Medical Center is a 428 bed non-profit hospital which operates a full service acute care community based facility. Bethany has a tradition of providing advanced cardiac care, including open heart surgery, angioplasties, and cardiac catheterizations. Consequently, patients with serious cardiac disease seek hospitalization at Bethany. Last year, HCFA ranked hospitals by mortality statistics for cardiac bypasses, and Bethany was reported to have one of the best survival rates in the country for this procedure.

The very nature of the hospital's services can intensely impact its mortality data. Bethany has a comprehensive cancer program fully approved for over 30 years by the American College of Surgeons, which includes a dedicated oncology unit and radiation therapy. 80% of the Medicare cancer patients were admitted with advanced disease in which death was a highly probable outcome. Likewise, Bethany has a separate physical rehabilitation unit which treats patients with severe chronic states such as stroke and spinal cord injury, conditions associated with increased probability of complications and death. The broad range of diagnostic and therapeutic services offered means that Bethany transfers virtually no Medicare patients yet receives in transfer and by direct admit patients who require advanced levels of care other hospitals may not be able to provide.

As an urban hospital, many of our elderly population often arrive in debilitated and emergent conditions. The level and type of service provided by Bethany Medical Center often results in patients hospitalized with a severity of illness level not recognized in the HCFA model.

Quality Assurance Process

As a hospital fully accredited by the Joint Commission on Accreditation of Health Care Facilities, Bethany Medical Center has demonstrated its ongoing commitment to substantiating its quality of care and to continuously improving that care. As part of its quality care commitment, all mortalities are reviewed by a peer review committee just as soon as all pertinent documentation is available. The review committee's function is to assure that appropriate treatments and all available measures are rendered to each patient consistent with patient needs and accepted medical practice. Mortality is only one of an extensive array of indicators which can and should be examined to determine quality, therefore, the scope of care delivered to all patients is continuously monitored by our medical staff and hospital departments through ongoing quality assurance mechanisms to address potential problems and to identify opportunities to improve care for our patients.

Thank you for the opportunity to comment on this data.

Bethel Deaconess Hospital
Newton, Kansas 67114 316 283-2700

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

We thank you for the opportunity to review the selected mortality information concerning Bethel Deaconess Hospital that your agency plans to release to the public in December. We are also pleased to have the opportunity to offer the following comments on this information.

We fully recognize and appreciate the interest that all of us, patients, third-party reimbursers, employers who finance health care coverage, providers, the general public, and various agencies of government have in not only the cost of health care service but also the quality of these services. To respond to this interest, much effort and creativity is being exerted in this hospital and others to develop reliable quality assessment instruments and mechanisms. We view the tabulation and the planned publication of selected mortality information by the Health Care Financing Administration as a part of this interest and attempt to assess and then to make a public statement concerning the quality of care provided to Medicare beneficiaries by hospitals.

We have great concern about the adequacy and appropriateness of the tabluation and analysis of mortality data done by HCFA to assess in conclusive fashion the quality of care provided to the patients and cases studied. The use of mortality data is a long-used and time-honored tool in the assessment of the quality of care in this hospital, and hospitals generally. It has often been referred to as "Death Chart Review." In this review the medical records of patients who died in the hospital were reviewed in depth by knowledgeable health care personnel to make assessments as to the quality and appropriateness of care provided. Mortality data constitute significant flagging or screening tools in carrying on quality review, but do not provide a conclusive quality assessment mechanism. Quality assessment is as

complex and many-faceted as is a patient's health status and the factors that contribute to it and must involve a variety of patient specific considerations. This can be done only through an examination of the care of specific individual patients in relationship to their health status and problems by those involved in their care.

For example, severity and seriousness of illness are not in a comprehensive way indicated by the statement of a diagnosis or disease category. Nor are such significant considerations indicated by the simple statement of mortality data. Other complicating factors that need to be considered are the patient's genetic background, the level of preventive health maintenance practices of the patient which would affect general ability to survive a health crisis, what level of health care the patient received before coming to the hospital, and the impact of utilization review and other managed care dynamics operating within the hospital environment.

An analysis of the deaths being reported in the mortality information for Bethel Deaconess Hospital shows that in all 55 cases death was a significant possibility due to the patient having a chronic illness. From the standpoint of age alone the patients who died constituted a frail vulnerable group in that the average age was 83. None of the deaths were unexpected by those involved in caring for them while patients in the hospital. Of the 18 patients who died within 30 days after being dismissed from the hospital, the average time elapsing between their dismissal and their death was eight days. Twelve of those dismissed were discharged to intermediate care facilities and five were transferred to skilled nursing facility units. This attests to the need for continuing care for these patients.

It is also noted that for half of the patients the imminence of death was recognized in that a "Do Not Resuscitate" order had been written after proper consultation and decision making. In the case of eleven patients crisis resuscitation procedures were carried out. In eight of these instances the patient did not survive the crisis. Death was not unexpected in any of the 55 patients' deaths because they were suffering with chronic disease. All of the patients who died had previous and multiple health problems.

Of the 55 deaths considered by HCFA in this study 20 percent were admitted through the emergency room, and 45 percent were living in a a nursing home prior to admission. It is also noted that 50 percent of the patients who died outside of the hospital within 30 days after being dismissed from the hospital died of a cause different from their discharge diagnosis.

Thank you for the opportunity to express our perspectives on the hospital patient mortality information and to share with you some information about these patients being reported in this study and report.

Most sincerely yours,

M. H. Ewert, President

COMMENTS ON THE HCFA MORTALITY DATA

Caney Municipal Hospital

Caney, Kansas 67333

DATA VERIFICATION

The data used by HCFA indicate that out of 93 Medicare admissions to the Caney Municipal Hospital in 1986, a total of 18 Medicare patients died within 30 days of that admission. Of these, 10 died while still a patient of the hospital while 8 died after discharge. Our own records indicate that 155 Medicare admissions occurred in 1986. Presumably this discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Our own records also indicate that of the 18 Medicare patients who died within 30 days of admission, 11 were still alive at the time of discharge or transfer. Of these 11, 5 died after transfer to a skilled nursing or nursing home level of care, 2 died after transfer to a tertiary care hospital, and 4 died in their own home. All of these deaths occurred in patients over the age of 71, with the average age of the patients dying being 79. In all of these cases, discharge planning to establish the appropriate level of care was an important part of the discharge decision.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis.

INTERPRETIVE REMARKS

In two of the diagnostic catagories, the hospital's actual mortality rate falls outside of the predicted mortality rate. Several factors may account for this difference.

1) In the diagnostic catagory of Cancer, 1 patient died while still and acute in-patient, 1 patient died after transfer to another facilty, and one died after transfer to swing-bed skilled lever care. All of these patients were over the age of 75 and death was the expected outcome at the time of this admission. All patients had had previous admissions and had been previously diagnosed as terminal. The predicted mortality rate of 6%-8% cannot be reasonably applied to three admissions. When applying the percentage calculation to such a small number the possibilities are limited: 33%, 66%, or 100%.

2) The second diagnostic catagory, Gastrointestinal Catastrophies, has a predicted mortality rate of 2%-98%. In this catagory the percentage is even further distorted by the small sample. There was one patient admitted, age 85, and this patient died. This results in a 100% actual mortality rate. Many factors have been known to increase the risk of dying. and one of these factors, of course, is age. Patients over the age of 85 may have 5 times the chance of dying as patients under the age of 65.

SUMMARY

Using the information gained in the review and analysis of the HCFA mortality list, it becomes even more apparant that quality cannot be measured by raw numbers. As providers of health care, and as consumers, quality assessment is indeed a commitment and a resposibility of the medical staff and the governing board. Monthly meeting include the review of many indicators, including death, which may indicate that investigation is necessary. Some of these indicators are such things as antibiotic usage, transfusions, surgeries, and incident reporting. This mechanism of peer review allows quality to be assessed on a patient by patient, case by case study, and in this way become an effective tool.

KS 28.1 Susan Barrett

CLAY
COUNTY
HOSPITAL

617 Liberty

Clay Center, Kansas 67432

(913) 632-2144

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Re: Comments on the HCFA Mortality Data
Clay County Hospital, Clay Center, Kansas
Hospital Number 170054

DATA VERIFICATION:

The data used by HCFA indicate that a total of 72 Medicare patients admitted to the Clay County Hospital in 1986 died within 30 days of admission. Of these, 54 died while still a patient in the hospital, while 18 died after discharge. HCFA reports that a total of 309 cases were used in their study which resulted in an actual mortality rate of 23 percent.

Our own records indicate that 552 Medicare admissions occurred in 1986. The discrepancy is probably a result of the fact that HCFA is not considering multiple patient admissions for their study. The total number of in-hospital deaths (acute care plus swing bed patients) for Medicare patients was 59. We are unable to explain the discrepancy between the total number of Medicare deaths listed on the HCFA report and our own records. We are also unable to verify the number of patients who died within 30 days after discharge. Therefore, using the figures for actual hospital admissions and actual hospital deaths, we arrive at an actual Medicare patient mortality rate of 10.7 percent.

It is impossible to determine the percentage of the patients dying after being discharged alive, as this information is not included in the patients' medical records. Also, without more detailed information concerning the billing information available to HCFA in computing the predicted mortality rate, e.g. complications and comorbidities, it is impossible to verify the accurance of the data used in HCFA's analysis.

We would like to point out that there are three errors in the ten cases listed in the Cerebrovascular Accident category: An incorrect date of death is listed for one patient; an incorrect diagnosis code is listed for one patient; the number of hospital Medicare cases in this category is incorrect.

(Continued)

INTERPRETIVE REMARKS:

In the category of Cerebrovascular Accidents, the hospital's mortality rate falls outside the range of the predicted mortality rate. The HCFA study states there were 12 cases of cerebrovascular accidents with a death rate of 10 cases within 30 days of discharge, for a hospital mortality rate of 83 percent.

After research of our hospital's data, it was found that there were actually 15 Medicare cases of cerebrovascular accidents during 1986 with a total of 8 in-hospital deaths, for an actual hospital mortality rate of 53 percent.

If the HCFA rate of 10 deaths within 30 days of admission is used, the mortality rate, without verification of the actual causes of patient deaths, using the 15 Medicare CVA cases identified by our hospital's statistics, is only 67 percent versus the 83 percent shown by HCFA. These figures are based on the assumption that all the cases were correctly assigned the proper diagnosis codes.

UNIQUE CIRCUMSTANCES WHICH MAY RESULT IN HIGHER THAN AVERAGE MORTALITY:

When examining the statistics for our hospital, one must keep in mind that this facility is located in an area where patients remain at home or are cared for in nursing home facilities until they are so ill that the only alternative is admission to an acute-care facility. To emphasize this, it is noted that of the 10 deaths in the Cerebrovascular Accident portion of the HCFA study:

8 cases had significant comorbid conditions, as outlined in HCFA's own criteria,

9 cases were patients who were so acutely ill that the attending physicians had written "Do not resuscitate" orders after discussion with family members,

8 of the 10 patients were completely unresponsive on admission,

and the average age of the 10 deaths was 84 years.

It is also to be emphasized that the standard of practice in this community is for patients who undergo less major cerebrovascular accidents to be maintained in nursing home facilities which have physical therapy capabilities similar to those of the acute care/skilled care hospital, or these patients are cared for at home by family members and attended by physicians who still make home visits and by home health agencies and outpatient physical therapy treatments. These same patients would be admitted to acute-care hospitals if they were located in larger, more cosmopolitan area, and the admission and subsequent dismissal of a number of less seriously ill patients would certainly lower the mortality rate in this category.

Sincerely,

Jon Robison

Jon Robison
Chief Executive Officer

CC: Kansas Hospital Association

CRMC
COFFEYVILLE REGIONAL MEDICAL CENTER
(316) 251-1200 • 1400 WEST 4TH • COFFEYVILLE, KANSAS 67337

October 23, 1987

Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Ref: Hospital Mortality Information - 1986
Coffeyville Regional Medical Center
Medicare Identification No. 17-0145

Dear Dr. Roper:

Coffeyville Regional Medical Center appreciates having had an opportunity to review and comment on the mortality information that HCFA plans on releasing to the public in December of this year. We agree with you that this information alone is not a complete measure of the quality of care at an individual hospital. Therefore, we must disagree with HCFA's decision to release this information because it is not conclusive and may tend to mislead the public about health services being rendered at our hospital. This type of raw data should not be released until such time as additional statistical and evaluating measurements have been developed to deal with the complex issues leading up to and causing death.

The information provided here does not take into consideration the various measures involved in determining the severity of the illness at the time the patient was admitted to the hospital. Specifically, you have not addressed whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, whether the patient experienced a history of chronic illness and/or repeated admissions to the hospital, or the patient's psychological state or general health status.

Since the information that is being reported reflects the <u>average</u> experience of some 6.5 million Medicare beneficiaries, it ignores any consideration of factors relative to state and/or local conditions. For instance it does not take into consideration that the state of Kansas ranks eighth in the nation, having an extremely large population of elderly over the age of 65. The material provided only reflects national information and, therefore, would not normally be significant to a particular hospital.

While the HCFA statistics indicate that Coffeyville Regional Medical Center's actual mortality rate was within the range of predicted mortality rates, in every category, there are significant problems with the reporting of data in such a raw state. Coffeyville Regional Medical Center recorded a total of 1,776 Medicare admissions for the year 1986, as compared to HCFA statistics of 1,021. This figure reflects that 64% of all patients to our facility in 1986 were Medicare beneficiaries. This indicates an extremely high utilization of Coffeyville Regional Medical Center by Medicare beneficiaries and recognizes that an aging population will have a higher utilization of hospital services due to their higher incidence of certain diseases.

During 1986 Coffeyville Regional Medical Center recorded a total of 148 deaths. Of that number, 142 were Medicare beneficiaries. Eighty-six percent of the Medicare deaths were patients over the age of 70. A total of 15 of the Medicare reported deaths died after they were discharged from the hospital, and records show that 60% of those 15 patients had a "poor prognosis" at the time of discharge. These statistics are indicative of an aging population in the Coffeyville area, and is also indicative of the disease categories which normally afflict an aging population; heart disease, cancer and pulmonary disease.

Due to the lack of Medicare approved skilled nursing beds in the Coffeyville area during 1986, it would be expected that Medicare patients would be admitted to an acute care setting during the last days of their lives, as no other Medicare facilities were available in the community.

Due to HCFA coding guidelines utilized during 1986, several cases that were reported under the heart disease categories in actuality had a terminal illness (such as cancer) upon admission to the hospital, and deaths in these cases were not unexpected. An individual review of medical records in which deaths occurred supports this fact.

Coffeyville Regional Medical Center over the years has provided services required by the patients in this area. The medical center maintains an ICU/CCU unit, an oncology service providing both medical oncology as well as radiation therapy. During 1985 and 1986 the medical center spent several thousand dollars to acquire specialized equipment for diagnostic testing and treatment of diseases in the areas of cardiology, respiratory therapy and oncology. Physician specialists in cardiology, respiratory therapy, oncology and radiation therapy visit the hospital on a regular basis to provide physician services in these indicated disease categories.

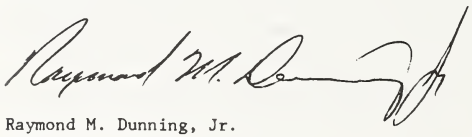
The development of our home health care program in 1985 was the first step to provide additional support services to the elderly in a home environment. The medical center will open a Medicare approved skilled nursing facility to provide those services that are not now existant in this community in January 1988. The medical center will also develop a Medicare approved hospice program in a further effort to meet the needs of the elderly and others in the community.

Coffeyville Regional Medical Center has been accredited by the Joint Commission on Accreditation of Hospitals since 1954. The accreditation process requires that hospitals participate in the review of pertinent clinical data to continuously and routinely evaluate the medical care being rendered at the facility. Routinely, deaths along with other pertinent medical information are reviewed by physicians and hospital staff to evaluate the quality of care being rendered at this facility. These quality studies are used to determine the level of care being rendered, and are also used to evaluate trends and unexpected outcomes.

The medical center by virtue of its accreditation with the JCAH is also accredited by the Medicare program. Medicare has, for several years, required hospitals to have individuals involved in the routine review of admissions and case reviews. Coffeyville Regional Medical Center employs three full-time registered nurses to be involved in the quality assurance program at this facility. These three nurses, along with other professional support personnel from several ancillary areas and the entire medical staff, routinely review all of the care provided at Coffeyville Regional Medical Center. It is the sincere intent of the hospital staff, the medical staff and the board of trustees to provide the highest quality care available and to adjust treatment protocols as may be determined proper by the entire medical community.

Therefore, we believe that the data being released by HCFA at this time is misleading, inadequate, and does not in any way attest to the true quality of services being rendered at any hospital. This kind of information is already being utilized by hospital and medical staffs in evaluating the levels of care being rendered at each institution. Until such time as HCFA or the Joint Commission or some other organization can develop accurate and meaningful ways to evaluate and judge quality; information such as that contained in this report, should not be released.

Sincerely,



Raymond M. Dunning, Jr.
Administrator

RMD:br

COMMUNITY HOSPITAL, ONAGA, INC.
120 WEST 8TH STREET
ONAGA, KANSAS 66521
(913) 889-4272

22 OCTOBER 1987

Henry Krakauer, MD, PhD
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P O Box 26684
Baltimore, Maryland 21207

Dear Dr. Krakauer:

There are several errors in your HCFA mortality data for Community Hospital, Onaga, Inc. (170045). The following need correction:

1. The legal name of the hospital is now Community Hospital, Onaga, Inc., not Community Hospital District 1.

2. The total Medicare patient admissions for 1986 should be 430 as follows:

Acute Medicare Patients = 382
Skilled Medic. Patients = 48
ALL MEDICARE ADMISSIONS = 430

3. Actual Hospital Mortality Rate for All Causes needs to be corrected from 13% to 5.6%, or 6%.

4. Actual Mortality Rates for the 13 diagnostic categories may also need correction, but without HCFA's data, it's impossible for us to verify the accuracy of these categories. Even at that, all of our hospital's rates were all very well within HCFA's predicted ranges.

INTREPRETIVE REMARKS: The data used by HCFA indicates that a total of 24 Medicare patients admitted to CHO, Inc. died within 30 days of admission. Of these, 13 died as inpatients, while 11 died after discharge. Our records indicate that 430 Medicare admisions (382 acute, 48 skilled) occurred in 1986. Using the HCFA formula, this indicates a 5.6% actual mortality rate for CHO, Inc.

HCFA's Range of Predicted Mortality Rates for our type and size of hospital is 10%-to-21%, with an average rate of 15.5%. We believe that our 5.6% rate, which is far below HCFA's predicted rate, signifies a high degree of quality care. The overall national mortality rate for all hospitals (11.7%) and the unusually high average age of our patient load give further support.

Of the 24 deaths reported by HCFA, the median age was 83.5 years, reflecting the fact that 27% of Onaga's residents are age 65 or over (compared to 13% and 12% for Kansas and the USA, respectively). Thus, we have a high incidence of end stage pulmonary disease, cardiac disease, and cerebrovascular diseases.

Of the 11 reported patients who died after discharge from CHO, Inc., we don't know what events might have occurred after they left the hospital. The oldest was 101 years young. Also, five of the 24 total deaths were skilled admissions. CHO, Inc. also offers swing bed skilled care, which targets the terminally ill patient, among others. Such a program naturally inflates the overall mortality rate.

Finally, our hospital monitors mortality rates as one portion of a larger Quality Assurance Program, but we believe the corrected data demonstrates the high quality of care delivered at CHO, Inc.

Sincerely,

Joseph Engelken, MPA
Administrator

Cushing Memorial Hospital

Charles L. Rogers, Administrator

623 MARSHALL • LEAVENWORTH, KANSAS • 66048 (913) 682 8000

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

Throughout its history Cushing Memorial Hospital has been concerned that the staff and facilities are organized to deliver optimal patient services. The hallmark of this community effort has been to successfully maintain Joint Commission Hospital Accreditation since 1958. The hospital has successfully employed clinical monitors and methods of identifying patient care problems and evaluating the results of treatment. The data listing prepared by HCFA indicates that 359 Medicare patients were dismissed from the hospital during calendar year 1986. Of these, 58 patients died in the hospital or within 30 days of discharge. They have calculated a mortality rate based upon this information of 16%. Our records confirm that 45 patients did expire in the hospital and we can assume that it is probably true that 13 more expired after discharge. One of the key information sources however, is not known whether the 13 died of the same condition which was present at discharge or merely the aging process. Interestingly, we have confirmed that during this same calendar year according to our records, 648 discharges were recorded. This is a serious variation and we have to conclude that the HCFA data is consequently flawed in some serious matter. We did not look into the listing on a case by case basis. We did find in a number of discharges that using the principle diagnosis as the assumption for the cause of death is not reliable. With these shortcomings in the HCFA listing we do not see how this report could be used even as a generalization of the events as an indicator of the outcome of care.

Sincerely yours,

Charles L. Rogers
Administrator

Enclosure
plk

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Decatur County Hospital

810 West Columbia
Box 268
Oberlin, Kansas 67749

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Washington, DC 20201

Medicare #170060

Dear Dr. Roper:

While we are very concerned about quality of care issues and encourage the public to make informed decisions, we must voice our objections to the methodology employed in your report on selective mortality. As a rural facility we average approximately 800 admissions per year, but have seen only a limited number of Medicare cases in several of the 16 diagnostic categories. Because of these limited Medicare admissions, we feel that the "actual mortality rate" is misleading rather than informative.

Under the category of severe trauma we had only one Medicare admission. Therefore, our mortality rate can be only 0 or 100 percent. This particular 91 year old patient was admitted with a broken hip (severe trauma) but with numerous complications. The patient died of respiratory failure as a consequence of coronary heart disease and chronic obstructive pulmonary disease. Publishing "actual mortality rates" to compare with "predicted mortality rates" based on one Medicare admission is not appropriate and is not reflective of our capabilities or your "sophisticated statistical techniques."

We recognize your efforts to make this information available but feel that these rates do not, in this case, reflect the type of care provided and only serves to confuse rather than inform. We would hope that in the future you would take into consideration the nature of the facility and the raw number of admissions in each category before publishing.

Sincerely,

Charles P. Myers
Administrator

mdk

Leased by Lutheran Hospitals & Homes Society

Edwards County Hospital

Lutheran Hospital Association

Telephone: 316-659-3621

P.O. Box 99

KINSLEY, KANSAS 67547

October 13, 1987

William L. Roper M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

I have spent many hours directly and indirectly considering how the statistical "Hospital Mortality Information" by hospital to be released later this year to be a benefit to my community in its present form.

I appreciate your statement, you will recommend in your comments this information in its self does not judge quality of care provided by a hospital.

The statistics for my hospital show for 1986; 127 medicare people were admitted under the 16 diagonsis reviewed with 21 people or 17% (your stated predicted percentage range being 12-26%) of these people died; some in the hospital and some within 30 days after being discharged from the hospital. The age of these patients range from 68-95. A further breakdown of the age group shows 1-60's; 6-70's; 7-80's; and 7-90's. What does this mean for Hospital Mortality Information? Does it allude that because these statistical people died, they didn't receive quality care?

As I write this letter, [redacted] died in his sleep two days after leaving the hospital. He is now a "Hospital Mortality Information" statistic. What does this mean? Lack of Quality Care?

I would appreciate any help you can provide to me to understand where you are coming from and where you are going with this. The elderly population deserve information they can readily understand.

Thank you,

D. G. Larson

D.G. Larson
Adminstrator

DGL/jw

Gardner Community Medical Center

427 West Main Gardner, Kansas 66030 913-884-8711

Response to 1986 HCFA Mortality Data
Gardner Community Medical Center
Medicare Provider Number: 170130

The Gardner Community Medical Center closed November 15, 1986.

Greely County Hospital
Tribune, Kansas

Provider Number: 17-0082

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

GREENWOOD COUNTY HOSPITAL

100 West 16th
EUREKA, KANSAS 67045
Phone 316-583-7451

PROVIDER # 170032

An Affiliate Of

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper,

In response to the mortality information for Greenwood County Hospital, I would like to clarify several items.

Your statistics show our hospital to be well within the acceptable limits except in your sepsis category. After investigating the three cases listed, we found that one case was transferred from our institution to an acute care bed in the V.A. Hospital in Topeka, Ks. and died there fourteen days after leaving our hospital. We have not been able to determine cause of death in this one case.

I would also like to address the fact that even though you state that age is a factor that is adjusted for in the predicted mortality rates, our average age at death from your statistics is 83.2 years. I feel that this is definitely older than the average in the majority of other hospitals in the nation. Our area is heavily populated by the elderly and because of this our Medicare patients make up approximately 70% of our patient days.

We review our own mortalities routinely and any questions which arise are taken to our consulting pathologist and then to our medical staff if necessary.

I feel the above-mentioned statements should be considered when assessing our mortality information.

Thank you for your time and attention.

Sincerely,

Nancy J. McKenzie

Nancy J. McKenzie
Administrator

NJM/pks

HIAWATHA COMMUNITY HOSPITAL

300 Utah Street
Hiawatha, Kansas 66434

Phone 913-742-2131

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and
Human Services
Health Care Financing Adm.
Washington, D.C. 20201

Dear Dr. Roper:

Hiawatha Community Hospital wishes to respond to the release of mortality information as accumulated by the Health Care Financing Administration (HCFA).

One diagnostic category of renal disease demonstrates the institution had one patient, and that one patient died, thus a mortality rate of 100%. Research has revealed that the individual involved was over ninety (90) years old, in failing health, and the end result anticipated. Therefore, this statistic should not be utilized in any assessment of quality assurance performance.

Thank you for this opportunity for input.

Sincerely,

J. Michael Frost
Administrator

JMF:jw

P.O. Box 15959
10500 Quivira Road
Overland Park, Kansas
66215
Telephone 913 541-5000

Humana Hospital
Overland Park

October 29, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P. O. Box 26676
Baltimore, Maryland 21201

RE: Response to HCFA on hospital mortality rates

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Overland Park supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

P. L. Ashbury, Jr.
Executive Director

PLA/lj

Hutchinson Hospital Corporation
1701 East 23rd
Hutchinson, Kansas 67502
(316) 665-2000

October 27, 1987

Mr. Harvey Brooks
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
2D2 Meadow East Building
Post Office Box 26684
6300 Security Boulevard
Baltimore, Maryland 21207

Dear Mr. Brooks:

Enclosed please find our comments on the HCFA Mortality Data. We are pleased to have the opportunity to comment. We continue to be concerned that those who read news releases on this subject matter will determine that the material presented addresses a lower than acceptable standard of care which it does not, in our opinion, speak to. We feel the information being made available should be principally used by hospitals to identify or suggest areas for internal review.

Sincerely,

Alvin I. Penner
Executive Vice President

ab

Enclosures

COMMENTS ON THE HCFA MORTALITY DATA
Hutchinson Hospital, Hutchinson, Kansas
Medicare Provider Number 170010

The data used by HCFA measures the relationship between mortality and a selected group of patient characteristics. It is important to recognize the limitations of studies and statistical methods which must be used. The ranges shown are predicted for patients with certain diagnoses. Some of the patient characteristics included in this study were age, sex and other medical conditions, however, other factors such as the stage of the illness were not considered.

201 Medicare patients were admitted to Hutchinson Hospital Corporation and died within 30 days rather than 202 patients as reported by HCFA. 151 of the 201 died while a patient rather than 147 as reported. Our records do not include information concerning death after discharge, therefore, we cannot confirm the accuracy nor the date of death of those who died post hospitalization. Two of the diagnostic categories we wish to specifically address are gastrointestinal catastrophes and cancer related deaths though the numbers do not exceed the printed averages the circumstances were reviewed so that we could more appropriately shed light on all factors that were being brought to bear.

Gastrointestinal Catastrophes

There were thirteen patients in this category. Twelve patients died in the hospital, one patient died after discharge. Due to the condition of the patient, 11 of the patients or their families had expressed their desire to no resuscitation with their physician prior to the patients death. The mean length of stay was three days, quite likely indicating the critical condition of the patient at the time of admission. The average age was 84 and all patients had other medical conditions which may have contributed to their deaths. Two diagnoses within this diagnostic category accounted for 83% of the deaths, they are intestinal obstruction and gastrointestinal hemorrhage.

Cancer Related Deaths

In this category there were 32 patients. The mean length of stay was six days and the average age was 74. Many of these cases had an advanced disease and other complicating conditions. A significant number were admitted because the family could no longer provide care in the home. In providing compassionate care it is frequently necessary for the patient to be hospitalized in the terminal stages of the disease for pain control and other supportive services shortly before their demise. The HCFA data does not reflect the relief of pain and suffering that this approach gives the cancer victim. Due to the condition of the patient, 30 of the patients or their families had expressed their desire for no resuscitation with their physician prior to the patients death. Of the remaining two, one had the cancer diagnosed on autopsy, the other died after being discharged. There were four patients within this group that their death was attributed to a suspected cancer but because an autopsy was not performed/granted, the diagnoses of cancer was not confirmed.

Hutchinson is a cancer referral center. Within our service area Hutchinson Hospital is the only referral center for cancer patients. There are two medical oncologists in the community who have privileges at the hospital. The community also has two home health agencies and an active hospice program. The hospital provides a cobalt therapy unit and a skilled nursing unit.

The HCFA data, in our opinion, is not, in itself, a measure of the hospitals performance. At best this can be used to better focus quality assurance activities. Under no circumstances should the data be used as a basis for judging the quality of care provided by the hospital. Quality can only be evaluated through the process of peer review -- not through simplistic statistical comparisons.

Hutchinson Hospital Corporation
1701 East 23rd
Hutchinson, Kansas 67502
(316) 665-2000

October 27, 1987

Hospital records indicate that the following patient was never treated as an inpatient at Hutchinson Hospital Corporation:

[redacted] Date of Death: 10/23/86

Hospital records also indicate that the following patients were treated at the hospital but the date of death reported by HCFA appears to be incorrect:

[redacted] Date of Death: 02/12/86 (Hospital)

[redacted] Date of Death: 11/26/86 (Hospital)

[redacted] Date of Death: 01/05/86 (Hospital)

[redacted] Date of Death: 07/26/86 (Hospital)

ATTACHMENT 5

October 27, 1987

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	19	13	19	13
CE -- Cerebrovascular Accidents	11	7	13	5
GC -- Gastrointestinal Catastrophes	13	1	12	1
GI -- Gastrointestinal Disease	5	1	5	1
GU -- Urologic Disease	0	0	0	0
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	4	2	4	2
HM -- Severe Chronic Heart Disease	14	5	15	4
HS -- Severe Acute Heart Disease	20	3	20	3
ME -- Metabolic/Electrolyte Disturbances	0	2	0	2
OP -- Orthopedic Disorders	1	1	2	0
PN -- Pulmonary Disease	24	4	25	3
RN -- Renal Disease	2	0	1	1
SE -- Sepsis	6	3	6	3
TR -- Severe Trauma	4	2	5	1
EU/~~OP~~ -- Ophthalmalogic Disease	1	1	1	1
UN -- Other Diagnoses	23	10	23	10
Total -- All Categories	147	55	151	50

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

KS 693

Kiowa District Hospital

BUCK McKINNEY, JR., *Administrator*

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810 Drumm Street
KIOWA, KANSAS 67070
316-825-4131

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

In response to your request for comments concerning the mortality rate of medicare patients in our hospital, we would like to say that the Kiowa District Hospital has always maintained the utmost concern for the rendering of quality care. Any indication of potential quality problems, including a mortality rate that is higher than predicted, would always lead to an investigation by our governing board, medical staff and administration.

The overall mortality rate for our hospital was within the predicted range, the only diagnostic category over the expected mortality rate was renal disease. In this category we had only two cases to review. We believe this is not a significant number of cases to be valid in determining a percentage rate. In both of these cases, the individuals had been in general ill health for some years. One case involved a ninety year old and the other an eighty-two year old. Both were in critical condition on admission to the hospital and both died. This makes our mortality percentage one hundred percent for this category and in turn brings our overall percentage up.

We strongly advocate quality control in all hospitals, however we firmly believe that measuring quality by mortality alone, is too definitive and does not take into account the individuality of each patient.

Sincerely,

Buck McKinney
Administrator
Kiowa District Hospital

October 16, 1987

TO: Health Care Financing Administration

FROM: Lawrence Memorial Hospital, Lawrence, Kansas
Medicare Provider #: 170137

Data Verification

The data used by HCFA indicate that a total of 137 Medicare patients admitted to Lawrence Memorial Hospital died within 30 days of admission. Of these, 105 died while still a patient of the hospital, while 32 died after discharge. Our own records indicate that 1,538 Medicare admissions occurred in 1986 compared to 987 reported by HCFA. Presumably the discrepancy reflects multiple admissions of individual beneficiaries. One death was reported in error. Twenty-two percent of the 137 patients included in the HCFA data are reported to have died after discharge from LMH; it is impossible to determine cause of death or date of death as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the HCFA analysis.

Interpretive Comments

It should be noted that this data applies only to Medicare beneficiaries, not a general hospital population. The mean age of the LMH patients in this study of mortality was 80 years.

HCFA states that the data could be useful for hospital medical staff and administration. At Lawrence Memorial Hospital, mortality review for all patients who die within the hospital is a regular part of an ongoing quality assessment program.

We have serious concerns about the statistical model developed by HCFA. The model measures the relationship between a limited number of patient characteristics and the risk of death. The model does not reliably predict hospital-specific mortality rates. The model also fails to consider a wide range of factors such as the state of the patient's illness or the patient's general health status. As the America Hospital Association pointed out, another limitation of the model is that it has not been validated. This model does not necessarily reflect quality of care at a particular hospital.

The HCFA model includes all Medicare patients who died within 30 days of hospital admission, whatever the cause. This model groups patients by admitting diagnosis, which may not necessarily reflect the cause of death.

In comparison of our own data with the HCFA data, we found comorbid conditions not included in the HCFA model to be present in the cases in our review. In other words, the HFCA model failed to consider all the factors that would influence outcome. (Comorbid conditions represent additional illness that may influence the patient's outcome.)

We hope that if HCFA continues to release such data, that the model be further refined and that it made clear that the data has limited usefulness and should not be used to judge the quality of care in a particular hospital.

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F.A.C.H.A., F.R.S.H.

Lawrence Memorial Hospital

325 Maine Lawrence, Kansas 66044 (913) 749-6100

THE LINDSBORG COMMUNITY HOSPITAL ASSOCIATION

An Affiliate of Great Plains Health Alliance

605 West Lincoln
Lindsborg, Kansas 67456
Phone 913-227-3308

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Roxbury, Kansas

ADMINISTRATIVE STAFF:

BRENDA S. O'GORMAN
Administrator

October 26, 1987

Health Care Financing Adminstration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

I write to respond to the mortality information about short term acute care at Lindsborg Community Hospital relating to Medicare patients treated in 1986. While I believe that the information is useful and a more accurate data base than HCFA has gathered in the past, I must go on record opposing its use as any type of quality indicator of service provided by our hospital. My reasoning supporting this assumption is twofold: first, the data lacks accuracy and completeness; and second, the model fails to measure a hospital's performance in providing quality care.

First, in reviewing our hospital's information, I found several discrepancies in the data. In the high risk category numerous contributing factors were not considered in evaluating these deaths:

* In nineteen (19) of the twenty-four (24) cases listed, the patients had chronic, debilitating diseases complicating their care, such as Metastic Cancer, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, etc.

* 79% of these cases receiving continuous or monitored supervision for their complicated conditons, i.e., in a Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF), or Home Health setting.

* Thirteen (13) of these cases had multiple admissions in the reporting period because of the conditions relating to the cause of their deaths.

* Two (2) of these patients chose to die by refusing treatment and/or heroic efforts.

- continued next page -

* In the Pulmonary Disease (PN) category which summarizes eleven (11) deaths, the average age of patients in this category was 82.

* 27% of the Pulmonary Disease category were documented on admission by the attending physician as not anticipated to survive.

In analyzing the information relating to the low-risk category, I also found inaccurate or incomplete data:

* Of the five (5) deaths reported in this category, the average patient age was 85 years.

* One patient refused prescribed treatment, choosing to die.

* One 80 year old patient survived surgery for a perforated colon; but died from the underlying history of chronic respiratory disease -- this case should not be included in this sample.

The category classifying all other conditons (UN) also holds misleading information:

* Three (3) of these cases should be included in the high risk category because their admitting diagnosis differs from the diagnosis describing cause of death which relates to those diagnoses in the high risk category -- Cerebral Vascular Accident, Metastatic Cancer, and Congestive Heart Failure complicated by Diabetes Mellitus.

* The remaining three (3) had blood disorders complicated by significant contributing factors.

* Two (2) of these cases came to the hospital to die.

The final category indicating a death within a year subsequent of admission of only one (1) case is completely inaccurate. This patient was transferred on December 30, 1986, for a specialty surgery in another acute care setting. The patient was discharged in January, 1987 from the other facility. This patient was brought dead on arrival to our emergency room of a cardiac arrest 15 days after transfer from our facility. The patient's spell of illness was never broken during this time. This case should not be included in our hospital's statistics. It was a transfer -- not a discharge. Of all the cases included in the mortality data, 44.4% of the focused deaths did not occur in our acute care facility. Many patients were receiving Skilled Nursing or Intermediate care.

- continued next page -

Second, I do not feel this model measures our hospital's performance in providing quality care to our community. Lindsborg Community Hospital is a rural acute care hospital and serves a unique community that cannot be compared to urban hospitals or even facilities of the same size in a different setting. Kansas is ranked eighth nationally for our high elderly population. Lindsborg Community Hospital's market serves even higher percentage of Medicare patients because of a large intermediate and long term care home located in our community and three (3) long term care facilities within a 15-mile radius to our hospital. We also serve small communities within a 35-mile radius with dense elderly population. Of our 520 total admissions, which includes all ages and payor types:

* The average age of our total case mix is 64 years old.

* 64% of our case mix are Medicare patients.

* The average age of our Medicare patients is 80 years old.

This graphically illustrates the overwhelming aged population of our market. Care is often further complicated by the distance and inaccessibility of health care faced by these beneficiaries. Without some measure of acuity or co-morbidity standards, mortality rates are non-descriptive. Of our total case mix, our hospital's mortality rate is 9.6% -- a positive rate considering the market, level of acuity, and co-morbidity factors served.

The fact that Lindsborg Community Hospital's mortality rates fall within the range of HCFA's predicted mortality rates, without the considerations described within my letter, supports the fact that our hospital is committed to providing quality care to our community in spite of the different environment of a rurual health care setting.

Respectfully submitted,

Brenda O'Gorman

Brenda O'Gorman
Administrator

BO'G/dz

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs,

I feel it is necessary to respond to the recently issued mortality data and the related concepts used to generate that data.

I do not believe that this particular data can be used as a "quality of care" tool. In many cases the severity of illness of a patient cannot be quantified and included in the mortality statistic.

In Memorial Hospitals case, we exceeded the maximum predicted rate for Severe Acute Heart Disease by .8 of a patient. The average age of those patients was 81 years of age. Four of the eleven patients expired on the same day of admission. This fact shows that the sample sizes are much too small to be considered as valid.

With relatively low volumes of patients , the propensity for a rural hospital to be thrown out of the acceptable limits is much greater than the larger facilities and therefore, in itself renders the inclusion of the smaller hospitals with high volumes of Medicare patients invalid.

Please consider the above issues of severity of illness and sample size in your review and release of this data. This data is in no way a monitor of quality of care and should not be construed as such.

Sincerely,

J.Gordon Stofer
Controller

MEMORIAL HOSPITAL, INC. 1000 HOSPITAL DRIVE, BOX 1166, McPHERSON, KANSAS 67460 (316) 241-2250

Accredited by the Joint Commission on Accreditation of Hospitals
KS 84

Memorial Hospital

600 Madison
Topeka, Kansas
66607

Bringing you innovative services...with a tradition of caring

October 28, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper,

Please include the following statement in the report of 1986 Mortalities for Memorial Hospital of Topeka, Kansas, Medicare Provider no.170138.

"Memorial Hospital is pleased that the total Medicare 1986 mortality rate for our facility was only 8% within a predicted range of 7 to 14%. This low mortality rate is reflective of the superb medical care which the public receives at our facility. In interpreting the data, it is important to note:

1. The mean age for all such mortalities within our facility was 79.2 years. The youngest mortality was age 65, and 88% were over age 70.
2. The highest incidence of death occurred within the categories: Cerebrovascular accident (stroke), gastrointestinal catastrophes, severe acute heart disease and metabolic/electrolyte disturbances. Of these mortalities:
   a. 64.7% were admitted in a "do not resuscitate" status
   b. 29% were non-responsive upon admission
   c. 21% expired in another health care facility.
3. By category:
   a. CE (Cerebrovascular accident):
      70% non responsive on admission
      20% responsive but with massive damage
      10% sudden cardiac arrest
   b. GC (Gastrointestinal catastrophes):
      86% "Do not resuscitate" on admission
      14% severe hemorrage.
   c. HS (Severe acute heart disease)
      45% admitted to ICU or comotose upon admission
      18% ruptured aneurysm
      37% myocardial infarction with complications.

d. ME (Metabolic/Electrolyte disturbances)
66% "Do not resuscitate" upon admission
17% admitted with drug toxicity
17% admitted unresponsive.

4. For all other categories, mortalities were below the predicted range."

Thank you for the opportunity to provide this information.

Sincerely,

Charles E. Beall

Charles E. Beall
President and Chief Executive Officer

CEB/jd

cc: Jack W. Snarr, M.D., President of the Medical Staff
Dick Geis, M.D., Medical Director
Harvey Schloesser, M.D., Chairman, Quality Assessment Committee
Karen Dunford, R.N., Director, Quality Assessment
Gerald Diviney, Executive Vice President
Mary Winters, Executive Vice President
Kansas Hospital Association

MERCY HOSPITAL

821 Burke Street / Fort Scott, KS 66701 / (316) 223-2200

Sisters of Mercy

October 20, 1987

Carolyne Davis, Director
Health Care Financing Administration
700 East High Rise Building
6325 Security Blvd.
Baltimore, MD 21207

SUBJECT: Mortality Data

Dear Ms. Davis:

In reviewing the mortality data to be published in the near future for the year 1986 for Mercy Hospital of Ft. Scott, it was noted that there were two cases listed under severe acute heart disease which were improperly coded. Please see the attached page for the re-classification of these cases which would bring the hospital within the predicted mortality rate for severe chronic heart disease. This correction should be made prior to the publication of the mortality rates.

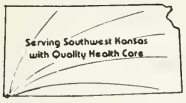
It was interesting to note that overall the hospital mortality rate was well within the predicted range. The Sisters of Mercy and the staff of Mercy Hospital have always committed themselves to high quality health care. It is our position that conclusions drawn from the publication of such data is extremely limited and in some cases can be misleading to the public at large. Historically, the Health Care Financing Administration has been involved in methods of accounting and statistical formats for measuring hospital costs. The evaluation and measurement of quality health care does not fit easily into these methodologies. If hospitals and their medical staffs are uncertain as to the methods used in making these various computations of predicted mortality, we seriously question how the Health Care Financing Admiinistration expects the public to understand these results.

Sincerely,

Andrew B. Lorimer
President & C.E.O.

ABL/gb

The hospital's commenta also included its written annotationa to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional commenta because of the numerous patient identifiers contained in these data.



Morton County Hospital
445 Hilltop • P. O. Box 937
Elkhart, Kansas 67950 Phone (316) 697-2141

October 24, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Wuality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Enclosed are the comments on the HCFA mortality data as it relates to Morton County Hospital.

Also enclosed is a copy of the list of patients included in the data and the worksheet for analysis of reporting errors.

We have been unable to locate the sheet which listed the predicability percentages for the deaths in the various categories for our facility. Would it be possible to have another one sent to our facility? We would appreciate having the list.

Sincerely,

Lowell M. Honson

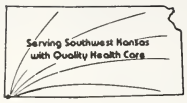
Lowell M. Honson
Administrator

LMH:bjh

Enclosures

COUNTY OWNED AND OPERATED

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



Morton County Hospital
445 Hilltop • P. O. Box 937
Elkhart, Kansas 67950 Phone (316) 697-2141
ID Number 170166

Comments on the HCFA Mortality Data

Data used by HCFA indicates that in 1986 Morton County Hospital had 145 Medicare admissions. Our date indicates 162 admissions. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to our hospital since HCFA data includes only the last admission for an individual if there were multiple admissions. There is no way to verify this information. The deaths reported were 68 years of age and older. The average age was 84.

The HCFA data has intermixed data from inpatient hospitalization with Swing Bed statistics. If HCFA is indicating the patient died in the hospital when the date of discharge is the same as the date of death, then HCFA indicates 10 deaths were in our hospital and 4 were out of the hospital but within 30 days of their last admission. Of the 14 HCFA indicates, we list 4 as hospital deaths and 10 as posthospital and within 30 days of their last admission.

Seven of the 10 posthospital deaths were in our Swing Bed Skilled category basically because the patient and the family chose to be in the hospital facility for supportive care. Four of these were cancer patients, one was renal failure, one was pulmonary, and the other was stroke. All seven had other coexistent disease.

Two of the 10 posthospital deaths were in the Morton County Care Center where they had been residents for some time and had other coexistent disease.

All four of the hospital deaths were patients who came in a critical condition with coexistent disease. Two of the patients had cancer. Two had heart problems and had been residents of the Morton County Care Center.

Factors which had significant impact were the patient's general health status, the stage of the patient's illness, the patient's psychological condition, and family support.

As a county hospital in an area of many older people, we care for all people. Our general practice physicians also specialize in heart and respiratory problems. Many of the patients we treat have coexistent disease. Many of the patients want to be in this area for treatment rather than at least two hours away from family and friends.

All of these variables have an effect on the mortality rate without necessarily affecting the quality of the care being provided by our facility.

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	1			1
CE -- Cerebrovascular Accidents	2		1 (with CA)	1
GC -- Gastrointestinal Catastrophes				
GI -- Gastrointestinal Disease				
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease				
HM -- Severe Chronic Heart Disease				
HS -- Severe Acute Heart Disease	2		2	
ME -- Metabolic/Electrolyte Disturbances	2	1	1 (with CA)	2 (1 with CA)
OP -- Orthopedic Disorders	1			1 (with CA)
PN -- Pulmonary Disease		2		2
RN -- Renal Disease	1			1
SE -- Sepsis				
TR -- Severe Trauma				
OP -- Ophthalmalogic Disease				
UN -- Other Diagnoses	1	1		2 (1 with CA)
Total -- All Categories	15	4	4	10

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

Mt. Carmel
Medical Center

Member CSJ Health System

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Medicare mortality data soon to be released to the public in and of itself is not an appropriate indicator of the quality of care rendered by a specific health care facility. Mortality is affected by numerous variables including, but not limited to:

1. the facility being either a referral or nonreferral center;
2. the specialty of a facility and its physicians;
3. the status of the patient at the time of admission (i.e., severity of illness, comorbidities and advanced age);
4. external environmental factors, occupational-related illnesses; and
5. a rapidly increasing elderly population within the facility's service area.

All of the above factors have a direct effect on the mortality rate of a facility without affecting the quality of care delivered by a specific provider.

Noted in the statistics provided to us in your September 21, 1987, mailing was the cancer mortality rate of 39% for Mt. Carmel Medical Center, which is 1% above the range of predicted mortality rates. Research of these cases on an individual basis revealed that almost all of the patients had a longstanding history of the disease with far-advanced metastases. In addition, 68% of these patients were over the age of 70 and most had severely debilitating comorbidities contributing to their compromised state. It is further noted that even though the cause of death was attributed to the primary diagnosis of cancer because that was the disease precipitating the hospital admission, some of these patients actually died of other causes, including multisystem failure or cardiac arrest.

Research has shown that southeast Kansas does have an abnormally high incidence of carcinoma which has been primarily attributed to the long-term effects of environmentals and occupational-related hazards

316•231•6100

CENTENNIAL
AND
ROUSE

PITTSBURG
KANSAS
66762

(coal mining). Incidentally, it follows that Mt. Carmel treats a very high number of respiratory diseases including COPD, black lung, emphysema in addition to the malignant conditions.

Mt. Carmel Medical Center does have an inpatient hospice program which receives referrals from a rather large surrounding area. Consequently, the patients who are in their final stages of disease come to our facility to receive palliative care without resuscitative attempts, medical heroics or artificial life support -- the concept of hospice.

Cobalt therapy is a service rendered at Mt. Carmel and the number of patients treated with this mode continues to rise. As our total count increases, so does the probability of increased severity of illness and terminal patients.

Accompanied with aging are other disease processes including cerebrovascular and heart disease. While our mortality rates for these categories do not exceed the range of predicted rates, we have researched these cases also and found no identifiable trends.

In summary, we reiterate that no direct "severity" factors are measured by these HCFA mortality rates because the information submitted to Medicare does not include the clinical characteristics needed to make such judgments. Furthermore, no one is exactly sure how "severity" should be measured. A higher probability of death occurs with advanced age and HCFA has made no public correlation with death to age or other disease risks.

Very truly yours,

Dan Lingor
President

jg

NEWMAN
MEMORIAL COUNTY
HOSPITAL

12th and Chestnut • Emporia, Kansas 66801 • 316-343-6800

October 26, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We have received and reviewed the mortality statistics for Medicare patients treated in our facility during 1986. Seven patients (Erwin, Reynol, Toms, Mark, Nealey, Bamesb, and Bastin) were not hospital deaths and could not be confirmed as accurate. Otherwise, the information listed appears to be correct.

The release of mortality information brings forth many questions, but really provides absolutely no answers. We are, at best, unsure how to utilize this information for any meaningful evaluation of the services at our facility. Through our routine Quality Assurance screening and Risk Management Program, which involves both staff and physician input, we feel that problems or unfavorable trends could more reasonably be identified.

I hope that, in addition to the public release of such statistics, the Health Care Financing Administration might consider issuing some qualifying statements regarding the limitations of your study model. We feel that the model fails to consider a wide range of factors relating to each patient which might impact mortality. Only through individual chart review, which is currently incorporated in our Quality Assurance Program can true problems be identified.

As the HCFA model is refined, it may become more useful in predicting hospital mortality rates. Currently, we foresee only potential for confusion and questions.

Sincerely,

Thomas H. McCall

Thomas H. McCall
Administrator

THM:sc

The William Newton HOSPITAL

Owned and operated by the City of Winfield

1300 E. FIFTH AVENUE :: WINFIELD, KANSAS 67156

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ADMINISTRATOR

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SECRETARY (EX OFFICIO)

October 21, 1987

William Roper, M.D.
Administrator, Health Care Financing Administration
Hubert H. Humphrey Building
Room 314G
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Re: Mortality Data for William Newton Memorial Hospital, Winfield, Kansas

On September 25, 1987 we received your letter and HCFA's selected mortality information for our hospital. Representatives of the medical staff have taken a careful look at the information to determine the appropriate use of the data to determine if it identifies any problems that would assist us to analyze the significance of this statistical information. Since there were only 80 patients, the charts of all of these patients were retrieved and are being reviewed. The first records selected for review are in categories having a mortality rate greater than 50% of the expected rate.

Perhaps the statistic that overwhelms anyone reviewing the information is the advanced age of most patients. Therefore, an analysis was made of the average age for each of the diagnostic categories. Exhibit A is a copy of your diagnostic categories, with the average age listed by each group. Another observation in the review of these cases, is that the prognosis of any of these patients was judged to be not good. It is hoped that this observation would not imply that diagnostic and treatment regimen should not be performed, when the prognosis is poor. A further review of the list includes two younger patients in the pulmonary disease category, with an age of 46 and 43. A review of these records indicates that the patients are multiple handicapped individuals from a state institution. They have Medicare coverage because of their multiple disabilities and any medical expert could predict that they had exceeded their life expectancy, probably attributable to the good care and attention they received over the years.

A COMMUNITY SERVICE
FOUNDED UPON DEVOTION

We are attempting to avoid any anecdotal rebuttal of why this is not valid information, but likewise we cannot find any creditable reason to conclude that this information alone measures anything related to the quality of medical care. A review of the patients' charts reveal that they were individuals with multiple chronic illness, and many complicating medical problems. There are no data to indicate that the mortality data identifies the severity of illness of these individuals. A lack of accurate information concerning the severity of illness index is an inherent flaw in the DRG system. Neither are there any data to recognize the distortion caused by small numbers of patient. Even though the use of a broader classification of diagnostic categories increases the volume, a distortion remains due to the small number of patients in some categories.

It is our understanding that when HCFA releases this information, it is implying that these statistics are a measurement of the quality of care provided in a hospital for these categories of illness. This information is so flawed that it defies any logical rebuttal. The deaths of these patients are representative of the frail elderly, with multiple chronic problems, and studying these statistics does not indicate a measurement of quality.

As a medical staff we strive to provide quality of care to all patients. Our staff is organized to provide high quality care to our patients and we monitor, study and evaluate many factors to ensure the quality of care. The mortality rates alone are not a measure of quality. They can be used to review certain areas along with the quality programs we have in place.

The overall mortality rate of 13% for Medicare patients in our hospital is within the predicted range, as are all of the other mortality rates. Perhaps we should be content to say that since we did not exceed any of the expected rates, this information is an indication of our superior ability to care for patients. However, we believe that these data alone are not indicative of quality and object to its use to imply that it measures quality of care in our hospital.

We represent the members of our medical staff, who have reviewed this information and conclude that this does not, in any sense of the word, measure quality of care received by a Medicare patient in any hospital, and should not be fostered on the public as a measure of quality.

This statement is on behalf of the William Newton Memorial Hospital Medical Staff.

Harold W. Steadham
Administrator

HWS:hg

EXHIBIT A

170019 NEWTON WM MEM HOSP WINFIELD KS

DEATHS	AVG AGE	DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
80	80.2	ALL CAUSES	604	13 %	9 TO 17 %
7	78.4	CA - CANCER	32	22 %	13 TO 45 %
8	79	CE - CEREBROVASCULAR ACCIDENTS	23	35 %	12 TO 40 %
1	92	GC - GASTROINTESTINAL CATASTROPHES	6	17 %	2 TO 63 %
7	87.2	GI - GASTROINTESTINAL DISEASE	80	10 %	2 TO 13 %
-	-	GU - UROLOGIC DISEASE	13	0 %	0 TO 41 %
-	-	GY - GYNECOLOGIC DISEASE	9	0 %	0 TO 100 %
2	69.5	HL - LOW-RISK HEART DISEASE	40	5 %	1 TO 17 %
7	82.7	HM - SEVERE CHRONIC HEART DISEASE	25	28 %	11 TO 45 %
9	83.9	HS - SEVERE ACUTE HEART DISEASE	21	38 %	24 TO 65 %
3	83	ME - METABOLIC/ELECTROLYTE DISTURBANCES	31	10 %	9 TO 40 %
-	-	OP - ORTHOPEDIC DISORDERS	20	0 %	0 TO 27 %
14	79.5	PN - PULMONARY DISEASE	64	25 %	12 TO 34 %
3	74.7	RN - RENAL DISEASE	11	27 %	13 TO 67 %
-	-	SE - SEPSIS	4	0 %	13 TO 89 %
-	-	TR - SEVERE TRAUMA	19	0 %	2 TO 32 %

KS 101.2

Northwest Kansas
Regional Medical Center

First and Sherman Streets Post Office Box 540
Goodland, Kansas 67735 (913) 899-3625

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Sirs:

Thank you for sharing the Mortality Statistics with us prior to publishing them. I am enlosing our comments to be published along with the statistics.

We notice two errors in the information you sent. [redacted] appears to be a duplicate of patient [redacted] of the preceding line. Patient [redacted] appears to be a duplicate of patient [redacted] also of the preceding line. Removing these duplications significantly reduces the mortality percentages for two of the diagnostic categories.

We have kept our comments brief to prevent an undue burden. We ask the public not to read more into the statistics than what really is there. Thanks again for allowing our comments.

Sincerely,

Rick Ketchum
Administrator

rak/sr

Enclosure

"Total Community Health Care"

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

COMMENTS ON MORTALITY RATES (1986)
NORTHWEST KANSAS REGIONAL MEDICAL CENTER
GOODLAND, KANSAS

We are pleased although not surprised that the statistics for the Northwest Kansas Regional Medical Center fall within predicted ranges. The hospital remains committed to providing quality care.

However, the reliability of the model used to produce this information is unknown. It fails to consider a wide range of factors with a significant impact on mortality. Many considerations are beyond hospitals control and therefore do not indicate appropriate nor inappropriate medical behavior. No allowance is made for the age of the patient nor the severity of the illness. We serve a large elderly population base that continuous to grow older. The older the population, the more deaths are likely. The data released by Health Care Financing Administration may identify potential areas for further evaluation, but does not address important considerations. Therefore this information should not be used as a basis for judging the quality of care provided.

The smaller numbers generated in rural health care settings create larger percentage rates (with the potential of exceeding predicted ranges) because the numbers are so small. One death could make an institution fall above the predicted rates if the total cases are are few. This is a statistical fact that has no bearing on quality.

The statistics for the Northwest Kansas Regional Medical Center are incorrect. Two patients included in the data are listed twice. This correction reduces Gastrointestinal Catastrophes catagory from 9 cases down to 8 and the mortality rate from 33% down to 25%. It also reduces the Pulmonary Disease catagory from 23 cases down to 22 and the mortality rate from 22% down to 18%.

The Northwest Kansas Regional Medical Center monitors the quality of patient care on an on-going basis. Our records are reviewed by the Kansas Foundation for Medical Care. Our internal reviews and their audits include:

1) Utilization review for Intensity of Service and Severity of Illness.

2) Evaluation of Readmissions.

3) Hospital-wide Quality Assurance Program with departments doing QA studies and reporting quarterly.

4) On-going Infection Control monitoring and monthly meeting.

5) Discharge Planning with attention given to level of care needed at discharge.

6) Deaths and unusual cases are reviewed by the Medical Staff in conjunction with consulting Pathologists. Blood and Tissue Statistics are reviewed similarily.

7) Pharmacy Therapuetics committee reviews antibiotic usage and any medication concerns.

8) On-going monitoring with weekly care team meeting for skilled care patients.

9) Monthly Safety Committee meetings.

We appreciate Health Care Financing Administration allowing hospitals to comment on the information. Our comments are intended to help all understand what the information might indicate and what it does not.

THE MAUDE NORTON MEMORIAL CITY HOSPITAL

220 NORTH PENNSYLVANIA

COLUMBUS, KANSAS
66725

Ph. 316-429-2545

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D. C. 20201

Re: Comments on the HCFA mortality data
Hospital Provider #170043

Dear Dr. Roper:

This letter is in response to the mortality data generated by HCFA. In the data verification process, a billing error of an incorrect principal diagnosis code was identified. Correction of this error changes the diagnostic category of the case. Attached are corrected copies of the HCFA case listing and mortality rate listing.

The data as presented is very limited and requires supplemental information for proper interpretation. It should be pointed out that in meeting the medical needs of our community, our hospital offers acute care and skilled nursing service. More than 50% of the patients admitted in '86 were more than 65 years of age. In this community, as in the state of Kansas, there is an extremely large population of the elderly.

Our overall actual mortality rate is within the range of predicted mortality rates. However, in one diagnostic category the hospital's actual mortality rate falls outside the upper range of the predicted mortality rate. In this category, which is a high risk of death category, it is to be noted that only two patients were treated. In fact, the highest number of patients treated in any one diagnostic category is very low, with the highest number being 28. We feel it is impossible to derive meaningful data from such an extremely small universe. Also, we emphasize that both patients had significant comorbid conditions and at the time of admission death was the expected outcome in one case and a significant possibility in the other.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

At Maude Norton Memorial City Hospital quality care is of the utmost concern to the hospital's governing board, management and medical staff. All deaths that occur in our hospital are monitored and evaluated by the medical staff. Through the hospital's quality assurance program, any indication of potential quality problems, including mortality rates, leads to a prompt investigation to determine if a problem exists. When quality problems are identified, corrective action is swiftly taken.

We feel the HCFA mortality rates do not measure quality. Mortality may be affected by many variables, all of which have an effect on the mortality rate without necessarily affecting the quality of care provided by the facility. Mortality data is appropriately used to focus peer review, in which quality can be truly evaluated. Simple statistical comparisons can not evaluate quality of care provided.

We emphasize that the existence of quality problems can only be determined by an indepth review of medical records, regardless of how rates of adverse occurrences compare with the national average.

Sincerely,

Carol Hays, ART
Quality Assurance Coordinator

PHILLIPS COUNTY HOSPITAL

Phillipsburg, Kansas 67661

An Affiliate of
Great Plains Health Alliance

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Re: Medicare Provider #17-0061

Dear Sirs,

The Phillips County Hospital Medical Staff has reviewed the mortality data and noted that we were slightly above the predicted range for severe chronic heart disease. Our institution services a rural area which is composed of a high percentage of senior citizens. Our past fiscal year showed that 65% of in-patients were Medicare. The review of all patients in the category "Severe Chronic Heart Disease" revealed an average age of 83.1 years.

The Medical Staff, assisted by consulting specialists, constantly review and monitor the care rendered here at Phillips County Hospital. Such care falls within generally accepted guidelines for an institution of our size and locale.

We feel this should be taken into consideration in light of the aged population in our area.

Sincerely,

Joanne Johnson

Joanne Johnson, R.N.
Administrator

JJ:hs

Plainville Rural Hospital District

Comprising Corning, Fairview, Greenfield, Hobart, Logan, Medicine, Northampton, Paradise, Plainville, Richland, Rush, Twin Mound, Walton Townships, and the City of Plainville, Kansas

October 12, 1987

Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

ATTENTION: William Roper, M.D.
Administrator

RE: Comments on H.C.F.A. Mortality Data

1. There appears to be some difficulty in the collection of mortality data. Two cases occurring during the month of January were omitted from the information recieved.

2. The development of the analytic methodologies is incomplete. If you do not take into account the severity of illness factor, the figures produced are meaningless. Also, it would appear that the model used has not been thoroughly tested to insure that the model produces the desired results on a constant basis. Because only one year's data has been used, and not all of the variables are included in the model, the reliability and validity of the model cannot meet acceptable statistic standards. Therefore, the release of such data is premature, at best.

3. The form in which the data will be released to the public is not shown so that we can see what we may have to defend.

4. How the number of all cases was reached by H.C.F.A. is not clear. Total Medicare admissions for this facility during 1986 was 207, but the H.C.F.A. report shows only 111. This is a significant difference. Multiple admissions for the same patient that had a positive outcome do not appear to be taken into account.

5. The average age of all deaths occuring in this group is 82.27 years. Yet, positive statistics, like this, are not going to be published. It would appear that only data that can produce a negative image is being provided to the public. This is a real disservice to the Health Care Industry.

Thank you for the opportunity to comment on the Mortality Data prior to it's release.

Sincerely,

Robert H. Lane

Robert H. Lane, Administrator
Plainville Rural Hospital
304 S. Colorado Box 389
Plainville, Kansas 67663
(913) 434-4553

RHL/cm

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

PRATT REGIONAL
MEDICAL CENTER

October 15, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to review and respond to Pratt Regional Medical Center's 1986 mortality data. We have reviewed and verified the information submitted. Even though Pratt Regional Medical Center is well below the "range of predicted mortality rates" as determined by HCFA, we still feel it is important for the public to realize the following:

1) Nineteen percent of the deaths attributed to PRMC occurred after discharge from this hospital. It has proven extremely difficult to determine a correlation between the patient's treatment and subsequent death following discharge.

2) Care given at PRMC is geared toward the elderly. More than half the patients discharged from PRMC are 65 and older. Of the deaths attributed to PRMC in 1986, the average age was 82.

3) Lastly and most importantly, the public must take into consideration the limitations of this data. It does not take into account severity of the patient's illness which is extremely important. Mortality rates are only one indication in determining potential problems with quality of care. Actual analysis of each individual case is then in order to determine whether a problem does exist and whether quality of care has been compromised.

Again, thank you for the opportunity to comment.

Sincerely,

Susan Page, RRA
Sr. V.P. Administration

c: Kansas Hospital Association

200 COMMODORE • PRATT, KANSAS 67124-3099 • (316) 672-7451

Providence-St. Margaret Health Center
8929 Parallel Parkway • Kansas City Kansas 66112 • (913) 596-4000

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Data Comments
Providence-St. Margaret Health Center
Medicare Provider #170146

Dear Dr. Roper:

In response to your letter of September 21, 1987, we have reviewed the Medicare mortality data provided for Providence-St. Margaret Health Center by the Health Care Financing Administration (HCFA). Per your data, Providence-St. Margaret Health Center's actual mortality rates fall within the range of predicted mortality rates for all diagnostic categories. We anticipate using this data in helping us to continue to ensure quality care at our facility.

While the data HCFA provided generally appear to be accurate, in our analysis and review we discovered some possible discrepancies. We determined that seven cases attributed to Providence-St. Margaret had died at other hospitals. However, when we calculated new rates based on subtracting these cases, it did not appear to make a significant difference in the actual mortality rates reported.

There also appear to be some minor variations between reported and actual dates of death. However, the actual dates fall within the 30 days of admission criteria HCFA established.

While we accept the overall report for Providence-St. Margaret Health Center, we believe there are several shortcomings to the model and methodology which should be addressed. HCFA has elected not to disclose the details of the methodology used, hence making it difficult to fully interpret the meaning of the predicted ranges. By HCFA's own statement, the data released are not valid for making comparisons between hospitals or as measurements of actual quality. Yet, our worst fear and anticipation is that this data will be used by the media and interpreted by the public for these comparative purposes.

For that reason, we urge that in publication of the data in December, that HCFA stress that the information is not valid as a basis for comparison of the quality of care at hospitals included in the study.

Providence-St. Margaret Health Center has a longstanding commitment to quality care and will remain committed to the high standards espoused by our own tradition and history, by the Joint Commission on Accreditation of Healthcare Organizations and by HCFA. We plan to seek ways to incorporate data provided in quality reviews at our facility, and we look forward to further refinements and communications about the methodology used.

Thank you.

Sincerely,

James J. O'Connell
Executive Director

JOC:jb

Riverside HOSPITAL

ROBERT DIXON
Administrator

2622 West Central • Wichita, Kansas 67203-4999 • Telephone (316) 945-9161

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Data - Hospital 170147

Dear Sir/Madam:

Pursuant to the 1986 mortality data presented for our hospital, we want to emphasize that Kansas ranks eighth in the nation for population of elderly over the age of 65 thus a high population in the 85 and over age groups as well. This may be a valid factor that indicates a higher mortality rate than that experienced in other states. The over 65 age group is over 42 percent of our hospital patient population.

Additionally, the data presented by HCFA based upon the ICD-9-CM codes is not a measurement of hospital performance and should not be construed as a basis for judging the quality of care provided by hospitals.

In a review of the mortality list and data provided for our facility, the following discrepancies are noted:

1. The total number of Medicare mortalities are incorrect in the HCFA listing.

2. Ten (10) cases have incorrect age of patients.

3. One (1) case has incorrect admission date.

4. One (1) case the date of death is in error.

5. The HS - severe acute heart disease indicates twelve (12) cases with ten (10) deaths with a mortality rate of 83 percent. Our records reflect fifty five (55) cases with thirteen (13) deaths with a mortality rate of only 27 percent.

   In the diagnostic category of high risk - severe acute heart disease an unusually large number of deaths are normally believed to be associated with such a diagnosis relative to other diagnoses included in this category.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

6. The data representing the number of Medicare admissions for 1986 shows two (2) patients admitted in December 1985 and expiring in January 1986.

In addition to the incorrect data, two (2) of the sixteen (16) diagnostic categories are utilizing the same ICD-9-CM codes 530 - 579 with some exceptions thus the validity of the data would be in question.

Eight (8) deaths in the mortality listing shows date of death later than discharge date or expiring after discharge from the hospital. These deaths should not be reflected in mortality rates for our facility.

In four (4) of the diagnostic categories, gastrointestinal catastrophes, gynecologic disease, severe acute heart disease and renal disease, the small population and sample does not support a high degree of validity. The results will be skewed from any normal distribution.

It is unfortunate that HCFA sees fit to present to the public, data that is not only incorrect, but includes data that has no relevance to the quality of care provided to patients of the facilities. You fail to consider for the public the comorbidities connected with the principal diagnosis, the severity of illness, the intensity of medical/surgical problems or the actual cause of death because of the principal diagnosis for which the admission is based upon or any of the conditions that develop afterwards. In my opinion HCFA is failing to discharge its responsibilities to the public, its more than paying less for more.

Sincerely,

ROBERT DIXON
Administrator

RD:bd

Enclosures

WE CARE
RUSSELL CITY HOSPITAL
200 SOUTH MAIN, RUSSELL, KANSAS 67665, (913) 483-3131

October 22, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26684
Baltimore, Maryland 21207

REGARDING: Russell City Hospital, Russell, Kansas 67665
Medicare Provider #17-0030
Response to 1986 HCFA Mortality Data

Dear Dr. Roper:

Thank you for sharing the 1986 HCFA Mortality Data with us and for the opportunity to respond to this data prior to its public release. Prior to commenting specifically on Russell City Hospital's data, I would like to make some general comments. Although you have stated in your explanatory letter to hospital administrators that you will make it clear upon public release that the information on its own is not a complete measure of the quality of care at an individual hospital, I am sure you are aware of the repercussions that occurred nationwide upon the release of the 1985 mortality data. With this in mind, I would think that HCFA would postpone any further public releases such as this until there were additional statistical measures to tie severity of illness and other complex issues to the mortality data. Providing such incomplete data often leads health care consumers to sometimes erroneous assumptions which they may or may not try to clarify by asking further questions of their physician or health care facility. The reliability of the HCFA model is unknown. It may accurately and reliably reflect the relationship between a small number of patient characteristics and the risk of death, but it does not reliably predict hospital mortality rates. It fails to consider a wide range of factors with a significant impact on mortality such as the patient's general health status, the stage of the patient's illness, the patient's psychological condition and family support.

Secondly and more seriously, HCFA's model has not been validated. Statistical analysis of mortality rates can do no more that screen for further review. The data to be released by HCFA raises important questions, but does not answer them. With this in mind, Russell City Hospital personnel have reviewed the statistical data provided by HCFA, compared it to our own data and to the patients' medical records, and we have the following comments.

The only specific diagnostic category that Russell City Hospital was above the high range of predicted mortality rates was Sepsis. Upon review of the only patient in this category, we find that this patient's sepsis was only one of multiple diagnoses and complicating factors, of which leukemia was considered by our physician to be the principal diagnosis. Sepsis was made the principal diagnosis for reimbursement purposes by the Kansas Foundation for Medical Care, our PRO. If the patient was moved to the cancer diagnostic category, as our record reflects that it should be, the mortality rate for the cancer diagnostic category would rise to 50%. However, this percentage of deaths is still within the range of predicted mortality rates for cancer patients.

RUSSELL CITY HOSPITAL
200 SOUTH MAIN, RUSSELL, KANSAS 67665, (913) 483-3131

The above also raises the concern of small hospitals with a much smaller patient load than larger facilities. With only one patient in a diagnostic category, if the patient expires, the mortality rate is 100%. It is difficult to stay within expected mortality rates when dealing with a small sample size, as reflected by this example.

According to HCFA's statistics, Russell City Hospital is above the range of predicted mortality rate for deaths from all causes combined, by one percent. However, it must be pointed out that HCFA's statistics reflect only a Medicare patient's last admission for 1986 and does not include the multiple admissions that often occur with patients in this age group. 248 cases are reflected in HCFA's statistics for Russell City Hospital. In actuality, there were 523 Medicare admissions to Russell City Hospital in 1986. If this figure(523) is used to figure the mortality rate, as opposed to using the 248 cases reflected in HCFA's statistics, Russell City Hospital's overall actual mortality rate for Medicare patients would be 8.8%, well within the range of predicted mortality rates for Medicare patients for all causes of death.

Patients' additional diagnoses, complicating factors, and comorbid conditions were not taken into account in HCFA's mortality data. By review of the medical records of these expired patients, 67% had diagnoses that are considered complications or comorbid conditions. Approximately 41% had documentation on the chart of a "No Code Blue"(or do not resuscitate) situation or documentation of the patient's or family's wishes that no heroic measures be taken.

Russell City Hospital has a skilled swingbed unit in which patients no longer requiring acute care, but still requiring a skilled medical need, can be maintained. Four of our 1986 deaths were patients in the skilled swingbed unit being managed at that level due to their deteriorating condition. It thus becomes obvious that death was the expected outcome of these admissions. In addition, of the seven deaths occurring after discharge, four expired at a nursing home where they were taken for continued convalescent care, one expired after being transferred to another hospital for further management, and two expired as patients being treated by home health care and were expected expirations due to the patients' diagnoses.

Another point of statistical significance is that adjustments for age in HCFA's statistical data have been made on a national basis and not on a per state basis. It should be noted that Kansas is ranked eighth nationally for our high elderly population. Russell City Hospital is located in a rural area with a very high percentage of elderly population. This fact is reflected in our hospital's death statistics which show out of 46 deaths, 7 of the patients were over 90 years of age, 16 patients were between 81 and 90 years of age, with the mean age of our 1986 deaths being 79. With this elderly population and the use of statistical data that does not take into account severity of illness, age, or other complicating diagnostic factors, it can be expected that we should fall above the national norm for predicted mortality.

WE CARE
RUSSELL CITY HOSPITAL
200 SOUTH MAIN, RUSSELL, KANSAS 67665, (913) 483-3131

I think it becomes apparent after our review of HCFA's mortality data that its validity is questionable. I appreciate the opportunity given to providers to respond to this data, but again I must repeat my concern regarding its release to the public because of its questionable validity and the repercussions it could have if interrupted incorrectly.

Sincerely,

Thomas J. Farley
President/Chief Executive Officer

TJE/mr

cc: Kansas Hospital Association

An Affiliate Of
GPHA
Great Plains Health Alliance

SCOTT COUNTY HOSPITAL
310 East Third Street
SCOTT CITY, KANSAS 67871

October 23, 1987

COMMENTS ON THE HCFA MORTALITY DATA
Scott County Hospital, Scott City, Kansas
Provider # 17/0085

The data used by HCFA describes mortality rates for a total of 165 Medicare patients admitted to Scott County Hospital in 1986. Our own records reflect that 294 Medicare admissions occured in 1986. Because HCFA identifies only the last admission of the year for patients having multiple hospital admissions, we are unable to verify whether the number of admissions attributed to our hospital in the HCFA study is correct. In general, the sophisticated methodologies used in developing this data make verification and analysis difficult.

HCFA states that this data release concerns "mortality information about all acute care hospitals", yet 6 of 23 deaths identified as expiring during their hospital stay actually died while receiving skilled nursing care services as part of the Swingbed Program. One of these patients did not have an acute care admission at Scott County Hospital within 30 days of death. The patient was transferred from another acute care facility for skilled nursing services of a supportive nature. This case may have been erroneously attributed to our hospital. Patients receiving skilled and intermediate care Swingbed services generally have significant complications and co-morbidities extending recovery or terminal conditions for which only supportive care is given. These patients should not be compared to the "average" Medicare patient in the "average" hospital that does not offer skilled and intermediate care services.

Scott County Hospitals actual mortality rate fell outside the predicted range in only the diagnostic category of sepsis. It is important to highlight the fact that only one patient was treated in this category. A data base of one patient significantly reduces the relevance of calculating a mortality rate. Medical record review demonstrated that the patient had been receiving radiation therapy for metastatic breast cancer and was treated for cystitis as an out-patient in another community just prior to admission.

While not above the predicted range, the actual mortality rates in two other categories may merit comment. The HCFA data demonstrates an actual mortality rate of 67% for the cerebrovascular accident category and a range predicted mortality of 5 to 69%. Again it should be pointed out that only six patients were treated in this category. Medical record review revealed that two of the four patients who died as a result of cerebrovascular accidents were transferred from a nursing home and both had a history of previous CVA. In all four cases, prognosis was grave at the time of admission and death was not unexpected.

A 50% actual mortality rate due to cancer was reported and HCFA had calculated an 8 - 61% predicted death rate. Generally, patients in our community initially seek treatment for cancer in larger cities, where specialists in the treatment of cancer and advanced radiologic and surgical services are located. But these patients often remain in the community for treatment if and when their disease becomes terminal. Thus cancer patients treated at Scott County Hospital are typically in the final phase of their illness. At the time the data for this report was collected, our community did not have an organized Hospice program and the hospital served as the center for terminal care. The medical records of all five cancer deaths were reviewed and four were found to be admitted for terminal care and demise during the stay was anticipated.

The governing board, management, and medical staff regard quality of care as an utmost concern and we applaud efforts to produce reports that will assure the public that the quality of health care delivered to all patients is consistently at a high level. We do not believe however, that conclusions regarding performance of hospitals can be drawn from mortality data. Mortality review is only one of several components in an effective quality assurance program and our hospital is continually involved in a wide variety of monitoring activities designed to ensure and upgrade patient care.

Thank you for allowing us the opportunity to comment on the 1986 Mortality Data and we appreciate inclusion of these comments with the public release of the data.

S
C

SEDAN CITY HOSPITAL

300 NORTH STREET P.O. BOX C SEDAN, KANSAS 67361 PHONE (316)725-3115

October 14, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Administrator:

The only actual mortality rate for Sedan City Hospital that does not fall within the predicted range of rates is in the diagnostic category of cancer. Since we had only one discharge in this category, which was a terminal cancer patient with the known outcome, our rate is naturally 100%.

When dealing with small hospitals who do not have many discharges the percentage rate goes up because of the lack of volume.

Also when compiling this data HCFA has no way of monitoring severity of illness or underlying diseases that complicate the initial illness.

Sincerely,

Lana C. Brewster

Lana C. Brewster
Administrator

Hospital ID#170106

SHAWNEE MISSION
MEDICAL CENTER

October 26, 1987

Dr. William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
P.O. Box 26684
Baltimore, MD 21207

RE: Hospital Mortality Information Comments
Shawnee Mission Medical Center
Medicare Provider Number 17-0104
Shawnee Mission, Kansas 66201

Dear Dr. Roper:

The Hospital Mortality Information for Shawnee Mission Medical Center has been reviewed and one (1) error was detected. Patient number [redacted] was reported to have been discharged on 6-13-86 and date of death 6-14-86. The patient died in hospital on 6-13-86. All other raw data, i.e., date of admission, date of discharge, date of death, etc., was correctly reported.

The accuracy of the raw data aside, there is concern about using ICD-9-CM coding as the sole criterion in compiling the report without including appropriate severity of illness and high risk procedures. The absence of this data severely jeopardizes the accuracy of the conclusions which will undoubtedly be drawn by uninformed members of the media and the public as a whole.

Further, when analyzing our patients coded as "Low Risk Heart Disease" we noted a number of patients with severe co-morbidities which were not taken into consideration for your classification. Complications, high risk procedures, and co-morbidities should certainly be included in the data and also be used to reclassify patients from the "low risk" to the "high risk" category.

The category of "Deaths Outside the Hospital" also offers some potentially misleading conclusions. Many of these patients were chronically ill upon admission and were being treated only for an acute episode. Several of our patients in this category had insisted upon being discharged to die at home with dignity.

Additionally, it was noted that the cause of death on a number of the patients often had no relationship to the principal diagnosis for which the patient was admitted. Examples included a patient admitted with a fractured hip subsequently dying from an acute myocardial infarction and a patient admitted because of dehydration with death attributable to cardiogenic shock post infarction.

Finally, the release of emotionally charged and sensitive data such as this possesses potentially damaging conclusions being drawn as to the ability of a hospital to deliver quality patient care. The HCFA should be held accountable for use of this data and provide the public with the necessary information to draw appropriate, intelligent, and reasonable conclusions.

Sincerely,

Fred J. Lucky,
Assistant Vice President

sf

Medicare Provider #17-0023

ST. CATHERINE HOSPITAL
608 NORTH FIFTH STREET • GARDEN CITY, KANSAS 67846
(316) 275-6111

Comments on Review of HCFA Mortality Data

St. Catherine Hospital conducts regular quality reviews on all mortalities to monitor and ensure the quality of care. We remain committed to ensuring and reviewing our quality standards and have conducted additional reviews after receiving the data from HCFA. Data submitted by HCFA indicate that a total of 67 Medicare patients admitted to St. Catherine Hospital died in 1986. After allowing for corrections, 56 of these patients died while hospitalized; 11 died within 30 days of dismissal. Of the 11 patients who died after discharge from St. Catherine, six were terminally ill.

These 672 total Medicare patients listed by HCFA account for 1,102 discharges from our hospital. Even though patients may be admitted more than once, HCFA only utilized data from the last 1986 hospitalization.

The hard data used by HCFA is based on the reason for admission and excludes consideration that death could be a response to a more serious illness. Seven of the eight patients who were categorized by HCFA with low risk admitting diagnoses had additional serious diseases not reflected in the HCFA data. In these instances, death was actually caused by the more serious condition. In addition, 35 of the 56 patients had requested no resuscitation or life support measures.

The mortality data submitted by HCFA cannot be used to measure quality of care. Quality judgements can only be made after review of the information contained in a patient's medical record. Mortality can be affected by such factors as stage and severity of illness, prior treatment, characteristics of the population served, patient's general health status, and more. Therefore, applying national averages to a wide variety of facilities and ignoring the importance of outside factors and individual review is not a valid tool for measuring quality.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

ST. CATHERINE HOSPITAL

HCFA MORTALITY DATA CORRECTIONS

Last Name	Patient #	CORRECTED DATA Admission Date	Discharge Date	Date of Death	Principal Diagnosis
[redacted]		10/07/86	10/07/86	10/07/86	150.8
[redacted]				10/06/86	
[redacted]				01/10/86	
[redacted]				08/16/86	

ST. FRANCIS HOSPITAL AND MEDICAL CENTER

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: MEDICARE PROVIDER NUMBER 170016

Dear Dr. Roper:

I am writing this letter in response to the data HCFA plans to publish regarding selected mortality rates for short-term acute care hospitals treating Medicare patients in 1986. While your office has released mortality data before, this represents the first time such data has been institution-specific. I understand your intention for this data is to "help consumers make more informed decisions about their health care" and help Peer Review organizations "determine if problems exist and, if they do, take appropriate actions to resolve them."

While I am appreciative of the opportunity to comment on the data release, I am most concerned about the inherent ability to confirm the data as accurate and the potential for misuse of any such data. Specifically, my concerns about accuracy include the following:

* You ascribe 249 deaths to this facility. Our data are only able to confirm 195 of these as occuring. We cannot validate nor duplicate the occurence of the other 54 deaths and, therefore, can ascribe no more than 76% accuracy to the numbers you send.

* In calculating "mortality rates" you divide the number of deaths occuring by the number of Medicare patients whose last admission occurred at St. Francis Hospital. You do not provide names of these patients. Our records show a substantially different number of Medicare patients admitted to St. Francis Hospital during the same period. You do not provide sufficient information to verify your number. Since this denominator is equally important to the calculation as the number of deaths, the resultant "mortality rate" cannot be confirmed.

* This total number of cases you provide (2,298) is not the sum of the cases listed by major illness category (1,591). No explanation is provided for this discrepancy.

* Lastly, you provide a "statistical model" which attempts to identify a "range of expected deaths". The source and validity of this model remains, according to your letter, "under development."

In light of the above, I must question the value of releasing inaccurate, unvalidated data against an unfinished formula.

Additionally, the release of even accurate mortality statistics tell very little about the quality of hospital and physician care. St. Francis Hospital is by HCFA measures one of the three most acute institutions in the state of Kansas. Thirty percent of the patients coming to the facility reside outside of Shawnee County. The patients who are hospitalized here are by your own measure far sicker than the average community facility. One would, therefore, expect that the mortality rate for this hospital would be higher (third highest?) than for other Kansas facilities. A high mortality rate may well be more a measure of the acuity of patients seen within an institution than the quality of care it delivers.

Lastly, let me assure you that the quality evaluation processes inherent in the operation of this hospital are substantial. Mortality review has long been a Medicare, Joint Commission, and state standard for hospital licensure and acreditation. Further, I would venture that no organized activity in which humans engage involves more systems of checks, monitors, screens, controls, peer review, and redundancy than the enterprise of operating a hospital. The functioning of these systems speak far more to issues of quality than any gross mortality data.

Sincerely,

Ingo Angermeier
Executive Vice President

rlr

4729

JAMES H. McFADDEN
Vice President, Professional Services

ST. FRANCIS REGIONAL MEDICAL CENTER

October 27, 1987

MEDICARE I.D. NUMBER
170122

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

We appreciate the opportunity to comment on the mortality data which your administration intends to release to the public in December 1987. Analysis and comparison of your data with our records was completed and we would offer the following information and observations:

I. Deaths attributed to have occurred within 30 days of the last admission to our hospital.

Our records indicate the following patients (identified by HIC Number) actually died in our hospital at the time of the stated admission, and not after dismissal as your data indicates.

This would reduce the number of deaths post discharge from 106 to 88.

II. Deaths identified as occurring in our institution.

A. Our records indicate the following patients (identified by HIC Number) were transferred alive from our hospital to acute care in another facility.

[redacted] [redacted]

These deaths, according to our understanding of the protocol, should be counted against the receiving institution.

B. Our records indicate the following patient (identified by HIC Number) did not die during the year of review. This patient had a subsequent outpatient visit to this facility in 1987.

[redacted]

III. Comments regarding the data release. Additional information and comments regarding our institution's death rate.

We are a tertiary referral center with major programs in transplant (cardiac and renal), cancer, cardiac diseases, dialysis, and a regional burn center. Our average age at death is 75. Our Medicare case mix index as published in the September 1, 1987, Federal Register is 1.5573, which places our institution among the top ten of all hospitals in the U.S. with the highest case mix indexes. The Federal case mix index is a numeral value which reflects the overall complexity and severity of our patients.

We agree that the development of comparative data on health care providers is desirable and in the best interests of our society. We believe, however, that the release of mortality data at its current level of sophistication, in and of itself, should not be viewed as a reliable indicator of institutional quality and performance.

The review of mortality data without the benefit of additional information on proximate causes of death, severity of illness, comorbid conditions and complications, stage of disease, condition of patient in admission and other relevant case management data, will not provide a reliable and just assessment. We question whether meaningful conclusions can be drawn and we fear that erroneous interpretations will be made.

We applaud the effort in both the Federal and Local level to develop sophisticated review systems. We hope that we can be a part of

developing criteria-based results oriented systems and look forward to developing mortality review in the future.

Sincerely,

James H. McFadden
Vice President

JHM/dyw

ST. JOHN DISTRICT HOSPITAL
609 EAST FIRST · PHONE 316-549-3255
ST. JOHN, KANSAS 67576

October 15, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The data used by HCFA indicate that a total of 12 Medicare patients admitted to this hospital died within 30 days of admission. Of these, 8 died while still a patient of this hospital, while 4 died after discharge. Our records indicate that 158 Medicare admissions occurred in 1986.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Our own records indicate that 10 of the 12 patients that died within 30 days of admission were in a high risk diagnostic category at the time of admission. All of the 8 deaths which occurred while inpatient were predicted at the time of admission and review of our records indicate that all these patients had orders for no-resuscitation.

Other factors affecting mortality rates for this hospital are the number of Medicare beneficiaries, this hospital provides services for a greater than average number of Medicare beneficiaries, and PRO coding guidelines. Because of PRO coding rules for cancer not being the primary diagnosis unless found during this admission one of the cases fell into a low risk diagnostic category which in fact that patient was in a high risk diagnostic category.

Sincerely,
Joyce Schulte

Joyce Schulte
Administrator

ST. JOHN'S HOSPITAL

ROY E. WHITE
ADMINISTRATOR

October 26, 1987

HEALTH CARE FINANCING ADMINISTRATION
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26884
Baltimore, Maryland 21207

RE: Response to Mortality Data of St. John's Hospital,
Salina, Kansas, Medicare Provider #170011

St. John's Hospital is commited to the concept and practice of quality assessment as evidenced by an active quality assessment program that has been in place for many years and seeking and attaining Joint Commission on Accreditation of Hospitals' accreditation status. Mortality data is only one variable in assessing and determining quality. Additionally, mortality data without case specific information can be confusing and misunderstood.

The mortality data report of St. John's Hospital indicates that all categories as presented by HCFA are within or below the ranges of predicted mortality rates.

The State of Kansas ranks very high in the percentage of the population over the age of 65. St. John's reflects in its census the age phenomenon of the State.

Sincerely,

Roy E. White
Administrator

REW/bk

139 NORTH PENN • P.O. BOX 1688 • SALINA, KS. 67401 • (913) 827-5591

St. Joseph Medical Center
3600 East Harry Wichita, Kansas 67218 (316) 685-1111

COMMENTS ON THE HCFA MORTALITY DATA

ST. JOSEPH MEDICAL CENTER, WICHITA, KANSAS

St. Joseph Medical Center recognizes that consumers have a legitimate interest in obtaining useful and reliable information on the quality of care provided in the hospital setting. However, the HCFA mortality data, by itself, does not measure quality. It should be used as a tool to guide peer review. St. Joseph Medical Center has used mortality data to focus our peer review for many years. We believe peer review is the only legitimate process for evaluating the quality of patient care. Because mortality data are easily misinterpreted, they can cause confusion and apprehension among Medicare beneficiaries and the public in general.

We, along with the American Hospital Association and many others, believe the mortality data should be used primarily by hospitals to identify or suggest areas for review. A mortality rate "higher" than predicted does not confirm a quality issue just a rate "lower" than predicted does not demonstrate that the hospital provides "high quality care". Actual mortality rates can differ from the predicted rate because patients treated at the hospital differ from the patients treated in the "average" hospital, or because the care provided differs from the "average" hospital, or simply by chance.

Quality patient care has always been an important consideration to the governing board, administration, and medical staff at St. Joseph Medical Center. The Medical Center has a Quality Assurance Committee which is responsible to the Medical Center's governing body for monitoring the quality of patient care and identification of potential quality problems. When potential quality problems are identified, the Quality Assurance Committee is responsible for the prompt investigation to determine if a problem, in fact, exists and when quality problems are identified, the Committee is responsible for swift corrective action. In the past, the Quality Assurance Committee at St. Joseph has dealt with such issues as: changes in hospital policies and procedures, limiting medical staff member's privileges, and removal of physicians from medical staff membership. St. Joseph is committed to insuring quality patient care services and will continue to take any and all actions necessary to insure quality patient care.

In reviewing the HCFA mortality data, several points should be kept in mind. First, the HCFA data is not all inclusive. The mortality rates apply only to Medicare patients, and are calculated using only deaths that occurred within thirty (30) days of the last admission of a Medicare beneficiary during 1986. Second, the HCFA predicted mortality rates are based on only a few characteristics which include: principle diagnosis; the presence of certain selected, complicating

illnesses; the patient's sex and age; the number of times that the patient was admitted to the hospital during the preceeding twelve (12) months; and whether the patient was transferred from another hospital. The statistical model used by HCFA does not include measures of severity (i.e., how ill the patient was at the time of admission, whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, or the patient's psychological state or general health status).

The data used by HCFA indicate that a total of three-hundred and sixteen (316) Medicare patients admitted to St. Joseph died within thirty (30) days of admission. Of these, two-hundred fifty-eight (258) died while still a patient of the hospital, while fifty-eight (58) died after discharge. The data identified by HCFA classified 76% (239) of the patient deaths with a high-risk diagnosis, while 24% (77) fall into the low-risk diagnostic categories as follows:

HIGH RISK

Diagnostic Category	No. of Deaths Reported by HCFA
CA-cancer	38
CE-cerebravascular accidents	18
GC-gastrointestinal catastrophies	11
HM-severe chronic heart disease	49
HS-severe acute heart disease	33
ME-metallic/electrolyte disturbances	19
PN-pulmonary disease	50
RN-renal disease	7
SE-sepsis	7
TR-severe trauma	7
TOTAL	239

LOW RISK

Diagnostic Category	No. of Deaths Reported by HCFA
EY-Ophthalmologic	0
GI-gastrointestinal disease	7
GU-urologic disease	2
HL-low risk heart disease	20
OP-orthopedic disorders	2
UN-other diagnoses	46
TOTAL	77

(continued)

Peer review of the mortalities in the cancer diagnostic category revealed that sixty-one percent (61%) were expected deaths (i.e., terminally ill patients with known advanced disease admitted for pain management, supportive/conservative care, and/or those patients having been referred to Hospice prior to or post-discharge and therefore whose demise could be anticipated during or shortly after hospitalization). The remaining thirty-nine percent (39%) were unanticipated deaths due to treatment complications and/or unanticipated clinical problems.

In reviewing the mortalities reported by HCFA which occurred following the patient's discharge from the hospital, at least four (4) of the deaths were unrelated to the patient's reason for admission.

The Medical Center's own records indicate several discrepencies from the data identified by HCFA. We identified sixteen (16) of the total cases listed by HCFA, that reported the incorrect patient age. Two (2) of the cases listed the incorrect date of death. There is a discrepency in three (3) of the principle diagnoses listed by HCFA. All three (3) listed a secondary diagnosis as the principle diagnosis. Finally, four (4) cases listed by the Department of Health did not identify a principle procedure that was listed on the medical abstract.

In concluding our remarks, we would like to emphasize that mortality rates such as this data being released by HCFA does not measure the level of quality care provided at a hospital. As stated earlier, we believe that peer review is the only appropriate process for evaluating the quality of patient care.

Finally, we would like to note that, while the HCFA mortality data is not a good indicator of quality patient care, St. Joseph applauds the efforts of the American Hospital Association and the Joint Commission on Accreditation of Healthcare Organizations in their efforts to investiate methods of evaluating hospital quality that rely on measures other than mortality rates, and that we look forward to the results of those efforts.

MS/tms

ST MARYS
HEALTH CENTER
"Quality Care With Christian Sensitivity"

15th & State
Emporia, Kansas 66801
(316) 342-2450

Inasmuch as you have done it unto one of the least of my brethren, you have done unto me." Matthew 25 40

October 27, 1987

William L. Roper, M.D.
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Mr. Roper:

Enclosed is our comments on mortality data at St. Mary's Health Center:

Quality of Care is very important at St. Mary's Health Center. Much time and effort is spent by the staff to deliver and assess the quality of care given at our institution. One part of that quality review is the mortality data. Physicians on the medical staff of St. Mary's review deaths that occur within the hospital.

In reviewing the mortality data prepared by HCFA, the raw data is accurate. Our institution does not have the ability to verify the predicted mortality rate. We do know that patient characteristics were used. Sample size is very important to make statistics valid. In a small institution the sample size is very small, two examples appear where only one case occurs per diagnostic category.

As stated before the mortality data is one part of quality review, but does not give a total picture of the quality care that is given at an institution. The Joint Commission, which gives hospitals accreditation, and the American Hospital Association are both working on methods to evaluate quality of care in an institution. Any methods that will make our review of quality of care better at St. Mary's Health Center will be appreciated.

Sincerely,

Mark I. Barnett

Mark I. Barnett
Chief Executive Officer

MB/le
Member of CSJ Health System of Wichita
Enclosure

STANTON COUNTY HEALTH CARE FACILITY

JOHNSON, KANSAS 67855

PROVIDER # 170117

October 7, 1987

Harvey Brook
Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Brook:

The data used by HCFA indicate that a total of thirty-six Medicare patients were admitted to Stanton County Hospital in 1986 for acute care. Our records indicate that sixty-three Medicare admissions occurred in 1986. In addition, Stanton County Hospital had two intermediate care and three skilled care admissions to its swing bed program during that same time period. HCFA's data also indicate that a total of four Medicare patients admitted to Stanton County Hospital died within thirty days of admission. Of these, three died while still a patient of the hospital, while one died after discharge. Our records, however, indicate that of the four Medicare patients who died within thirty days of admission, one patient actually died five days after being discharged from inpatient acute care and was admitted to the skilled care swing bed program; one patient actually died as an inpatient rather than from a post discharge status.

In one of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. Several factors may account for this. The one patient who died within this category had two comorbidity factors (DRG codes 427.5, Cardiac Arrest, and 582.9, Chronic Glomerulonephritis). The attending physician expected the fatality based on the severe factors of comorbidity.

Although data indicate that Stanton County Hospital is well within the range of predicted mortality rates for all causes, the record should reflect other variables that possibly may have contributed to the other three listed deaths. These patients, because of their advanced age, were probably expected to have died. All three were patients of either our Long Term Care Unit or Swing Bed Program. With Stanton County Hospital's committment to provide quality extended and swing bed care, the community's expectation of this level of health care delivery and an increase in the level of extended care, our patients admitted to inpatient care are not always average in relation to the specific characteristics used by HCFA for statistical

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

STANTON COUNTY HEALTH CARE FACILITY
JOHNSON, KANSAS 67855

analysis. Chronic degenerative conditions and comorbidity factors are quite often prevalent which influence the expected outcome of patient treatment and care.

Through the preceeding description of patient, institutional, and communal characteristics, I hope the community of which Stanton County Hospital serves will have a better understanding of the quality of provider care.

Sincerely,

Charles M. Smith

Charles M. Smith, MPH
Administrator

CMS/pms

STEVENS COUNTY HOSPITAL
1006 S. Jackson, Box 10, Hugoton, Kansas 67951

October 7, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Medicare Provider #170089

Dear Dr. Koper:

In response to your letter of September 21, 1987, we feel that there are some necessary comments which need to be made prior to making the information public knowledge.

In your letter, you stated that our review of your data will help you to prevent disclosure of inaccurate information. While we are in agreement with the accuracy of the data on our facility as presented, we do feel that HCFA needs to thoroughly explain the statistical data to the general public prior to releasing that information.

For example, our hospital had only one admission under the diagnostic category of "Gastrointestinal Catastrophies." This person subseqeuntly expired the day following admission, therefore we have 100% actual mortality rate for this diagnostic category. We feel this particular information to be very misleading to the general public and HCFA needs to explain the reason for the 100% actual mortality rate.

Our facility is a small, rural hospital with twenty-two acute-care beds as are the majority of hospitals in western Kansas. In all probability, the other small hospitals in our area would have approximately the same statistical data as our facility. This also needs to be stressed to the public.

In addition, while we understand the purpose of including those persons who expired after being discharged from our hospital, we feel that this information is not relevant to the purpose of your report. The two individuals you identified on our hospital report who expired after dismissal, were patients who had terminal, incurable diseases. According to documentation available in the medical record, in both cases it was the decision of the patients' families that no resuscitative, heroic measures be taken and that the patients were to be made as comfortable as possible. One individual had terminal cancer and the other had irreversible, complete heart block. The physicians and nursing personnel involved in these cases did all that was humanly possible in providing care and treatment to these individuals.

continued.....

October 7, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration

In summary, we ask that you take our comments into consideration before publicizing your findings and thoroughly evaluate the findings of HCFA to avoid the misunderstandings that will undoubtedly occur if proper explanation of the statistical data is not given.

Thank you for your time and consideration.

Sincerely,

Carlyle Kiehne, Administrator
Stevens County Hospital

Clifford L. Frink, R.N., F.N.P.
Director of Clinical Services
Stevens County Hospital

CK/kw

Stormont-Vail
REGIONAL MEDICAL CENTER

October 28, 1987

HCFA/HFQB
Hospital Mortality Information
Meadow East Building - Room 2D
6300 security Boulevard
Baltimore, Maryland 21207

Dear Sir:

This is in response to your September 21, 1987, letter concerning 1986 mortality information for Medicare patients treated at Stormont-Vail Regional Medical Center.

We have reviewed the information and have noted below our comments.

1. The following errors were noted:

   a. On page 4 of 6, patient #13435011 was listed twice.

   b. On page 6 of 6, there are seven patients that were admitted in the 1985 calendar year. These patients should not be in the 1986 count.

   c. With the changes noted above, the mortality rate decreases for the following categories:

	From	To
--- Cancer	9%	7%
--- Severe Chronic Heart Disease	24%	23%
--- Pulmonary Disease	20%	18%
--- Severe Trauma	18%	16%

2. Due to the manner in which the data is aggregated, we have serious reservation concerning its validity.

   a. Over twenty percent of the patients did not expire at Stormont-Vail. It was not possible to determine if their death was related to the illness for which they were admitted.

   b. The diagnostic category used for grouping the mortality data is based on the admitting diagnosis. This may be

totally unrelated to the cause of death; e.g. a renal patient having a heart attack.

c. Using the actual mortality rate to compare hospitals within a local area ignores the differences in the severity of illness of the patients treated; e.g. patients admitted to a major regional referral center versus a community hospital providing no tertiary care.

3. Every mortality at Stormont-Vail undergoes a comprehensive review process. This case-by-case analysis is a much better measure of quality medical care than the use of aggregated data which can be distorted because of problems of accuracy and validity.

4. An appropriate assessment of any hospital's performance is dependent upon many variables and requires a look at many quality indicators of which mortality is but one.

Sincerely yours,

Guy Almeling

Guy A. Almeling
Executive Vice President and
Chief Operating Officer

lf

cc: Kansas Hospital Association
Judy Slough

WAMEGO
CITY HOSPITAL

711 GENN DRIVE • WAMEGO, KANSAS 66547

October 15, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Wamego City Hospital
Wamego, Kansas 66547
Provider No. 17-0128

Dear Dr. Roper,

After review of this hospital's mortality information, I would like to draw to your office's attention a few points regarding the data.

-- This hospital data only indicated one admission for Renal Disease [redacted] during the dates of data collection. The death of this one patient subsequently indicates a 100% mortality rate in this category. Therefore, we would greatly appreciate care taken in the presentation of this data as percentages alone can certainly be misleading.

-- Care should also be taken in the presentation of data relevant to those patients who died after discharge from the hospital. Did they die from the condition for which they were admitted? or from another cause?

Thank you for the opportunity to review and respond to this information. However, like any other data, it can be either used to constructive advantage or misused by those unfamiliar with the background of the information.

Respectfully,

Lannie W. Zweimiller
Administrator

LWZ:jb

cc: Kansas Hospital Association

Wellington Hospital & Clinic

Dr. L.R.Will Dr. J.M.Baker Dr. D.R.Barr

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

TO WHOM IT MAY CONCERN:

I would like to take this opportunity to comment on the Hospital Mortality Information that HCFA plans to publish in December, 1987.

While the specific numbers for my individual hospital fall well within the range of predicted mortality rates in all diagnostic categories except one, I strongly believe that the rationale used for justification in publishing this information is flawed and that when published, the information will mislead the public, will be misinterpreted by the media and it is questionable as to whether or not it will serve any useful purpose at all.

Regardless of HCFA's intention to make it clear that the information on its own is not a complete measure of quality of care at an individual hospital, I believe this disclosure may be read by consumers as a guide to hospital performance and quality when, in fact, the relationship between mortality rates and hospital quality is weak, at best.

The only diagnostic category in which my particular hospital had an actual mortality rate higher than the predicted range was Renal Disease. The predicted range is 5% to 94%. We had 2 cases; one patient 71 and one age 91, both died. Our actual mortality rate was 100%.

With a sample size of two, there is absolutely no statistical validity to this data, yet it will be published that our hospital had a higher than predicted mortality rate for patients admitted with renal disease.

A quick glance at some of the ranges of predicted mortality rates further exemplifies the questionable value of this information. For example, the predicted mortality rate for Gynecologic Disease is 0% to 100%; for Metabolic/ Electrolyte Disturbances it is 1% to 81%; for Orthopedic Disorders the predicted rate is 0% to 95%.

It is difficult to believe that with a predicted mortality range of 0% to 100% or 0% to 95%, any significant or useful conclusions can be drawn relating hospital mortality rates with quality of care.

924 S.Washington-Wellington, Ks. 67152 (316)326-3353

Another problem with the data as it relates to my hospital and the majority of Kansas hospitals, which are rural, is the small sample size used. There can be no statistical validity when samples are so small. Also, adjustments in the data for age were made on a national basis, not on a per state basis. Kansas has an extremely large population of elderly over the age of 65, ranking eighth nationally. This fact would skew the figures negatively for Kansas hospitals.

I would like to re-emphasize that, in my opinion, the HCFA data are not, in themselves, measures of the quality of a hospital's performance. At best, they may be used to identify areas that may need further evaluation. They should never be used as a basis for judging the quality of care provided by hospitals.

Sincerely,

Terry Deschaine

Terry Deschaine
Administrator

TD:pg

(316) 356-1266

Established 1951

Bob Wilson Memorial Grant County Hospital

415 North Main Street

Ulysses, Kansas 67880

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

HOSPITAL: 170110

RE: HCFA MORTALITY DATA

Gentlemen:

The Health Care Financing Administration release to the communication media of the mortality data, as presently constructed and calculated as a "quality indicator" of the care being provided by an individual hospital, does not provide sufficient information for the general public to assess whether "quality care" is or is not being provided. There is a general concern that individuals who hear or read only percentage data may form unwarranted conclusions, fear health care providers, and avoid or delay seeking needed care.

The methodology for calculating the data does not address all of the variables which can and do impact on the deaths experienced in a specific hospital. Factors which are not identified in the data include: severity of illness, duration or progression of the illness, severity of any co-existing conditions, the general condition of the patient at time of admission, and the timeliness in which the patient sought medical intervention. This approach makes no reference to individual patient or family desires to discontinue medical efforts to sustain life. The predicted mortality rates or actual rates attributed to the hospital does not explain the reduced number of hospital admissions or that only the more seriously ill patients are being admitted to hospitals. Hospitals, such as ours, without access to hospice programs may well have higher mortality rates than a hospital located in a community with an effective hospice program.

Bob Wilson Memorial Grant County Hospital is a small, rural facility (only hospital in the county serving a population of 6,810) of less than fifty beds with fourty-one percent of the patient days being generated by Medicare beneficiaries, the over sixty-five age group. With reduced volume of patients, the total number of cases in each diagnostic category is very low; therefore, percentage mortality could be 100% if only one patient were in a particular diagnostic category and died in our facility.

The data used by HCFA indicate a total of 174 Medicare patients were admitted to the hospital within thirty days of death and twenty-two of that number died in calendar year 1986. Of these, it is reported that fifteen died while in the hospital and seven died after discharge. Our records indicate there were 306 Medicare patients admitted, with twenty-three deaths (seventeen died while in-patients, six died after being discharged from acute care (one died while in swingbed level of care). Of those who died after discharge, ultimate prognosis in four of those cases was determined to be poor by the attending physicians. Of the patients who died while hospitalized, five were admitted for planned terminal care; ten additional patients and/or their families elected, shortly after admission or during the course of stay, to discontinue medical activities to sustain life.

In the diagnostic category for sepsis, the actual mortality rate for the hospital falls outside the predicted mortality range. There were two patients in this category, both of whom died. One patient was a seventy-four year old female with septicemia, (with positive blood cultures for Staph aureus) whose condition was complicated by chronic renal failure, hypertensive and arteriosclerotic cardiovascular disease, and congestive heart failure. The other patient was a fifty year old male whose septicemia was due to massive infected pressure sores on his buttocks with secondary diagnoses of mental retardation and far advanced idopathic convulsive disorder with cerebral deterioration. This male patient presented for medical care late in the course of the illness, and was hospitalized less than twelve hours at the time of death.

The patient death not identified and the correction of date of death as stated in the HCFA Data are underlined in the attached line listing.

Thank you for the opportunity to comment on this information prior to its being released to the public.

Sincerely,

Wally Boyd

Wally Boyd, Administrator
Bob Wilson Memorial Grant County Hospital

WNB/bsl

PATIENT ID NUMBER (HIC)	SURNAME	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINIPAL DIAGNOSIS	PRINCIPAL PROCEDURE
		CA	076	M	12-19-86	12-30-86	12-30-86	20280	
		CA	071	M	07-29-86	08-04-86	08-04-86	1976	5491
		CA	082	F	07-15-86	07-18-86	07-18-86	1519	
		CE	092	M	07-13-86	07-20-86	07-20-86	436	
		CE	081	F	01-18-86	01-23-86	01-23-86	436	
		CE	091	F	12-04-86	12-08-86	12-08-86	436	
		GC	078	F	08-19-86	08-20-86	08-20-86	5609	
		HL	072	M	03-01-86	03-04-86	03-12-86	42731	
		HM	072	F	04-22-86	05-08-86	05-14-86	4280	
		HM	079	M	07-16-86	07-29-86	07-29-86	4254	
		HM	087	F	05-30-86	06-10-86	06-25-86	4280	
		HS	074	M	10-21-86	11-17-86	11-17-86	78551	
		PN	080	M	02-01-86	02-10-86	02-25-86	486	
		PN	074	M	09-27-86	10-04-86	10-04-86	486	
		RN	088	M	04-21-86	04-24-86	04-24-86	5849	
		RN	051	M	09-03-86	09-05-86	09-05-86	586	
		SE	050	M	08-11-86	08-12-86	08-12-86	0389	
		SE	074	F	07-24-86	08-06-86	08-06-86	0381	
		UN	076	M	06-13-86	07-04-86	07-04-86	2898	
		UN	073	M	02-21-86	03-04-86	03-07-86	7991	
		UN	070	M	02-11-86	02-22-86	02-22-86	7991	9392
		HS	075	M	01-11-86	01-12-86	01-12-86	4109	
		GI	090	F	12-06-86	12-11-86	01-05-87	56211	

KS 155.2

Wilson County Hospital

205 MILL ST., P.O. BOX 360
NEODESHA, KANSAS 66757
316-325-2611

#17-0073

Through all the debate on the significance of the mortality data released from HCFA, one fact is continuously pointed out. The data are not a reliable indicator of quality. The information supplied by HCFA on Wilson County Hospital is a primary example of the shortcomings of the data.

Initially, HCFA reported 140 Medicare admissions to our facility for 1986. The actual number of admissions was 248, representing 219 different patients. Using these figures, the actual rate of death was 14 percent; much lower than the 22 percent reported by HCFA. Of the discharges, five were discharged with a diagnosis of septicemia. All five of those cases resulted in death, which puts the death rate at 100 percent for this diagnosis. A sampling of this size would be what statisticians call "not statistically significant". In other words, there were not enough patients with this diagnosis to tell whether or not the fact that all of them died meant that they were not receiving quality care.

But lets look more in depth at the patients that were reported in this category. The average age of the five patients was 81.2 years. This is fairly representative of all of our Medicare patients. Wilson County has over 19 percent of its population over the age of 65. It is obvious that we serve a large elderly population, which would cause a higher than average death rate. In addition, the patients in this category were in a deteriorated state when admitted, and had many complications related to the cause of death. All of the patients had been treated for some time prior to hospital admission. Upon admission, three of the patients had an expected outcome of death. Three were admitted from nursing homes where they had been treated for their illness for some time. Two died on the date of their admission. One died of progressing cancer five days after discharge.

So what does all this information have to do with the death rate? Of the patients identified, all were older, debilitated patients who had been sick for some time. While their death was not always the expected outcome, it was inevitable.

Quality care cannot be measured by simple, inaccurate, statistics. Quality care can be measured by evaluating the overall care the patients receive by the physicians and staff at the hospital. Wilson County Hospital takes great pride in our staff and employees, as well as the care which we give our patients. The results of this pride is shown by the State and Medicare inspections which we pass every year. Medicare does have quality indicators built in to its system through the Peer Review functions and annual certification inspections. There is no need to confuse the issue with these inaccurate data releases.

Kentucky

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																												
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease											
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent							
ALLEN CO WAR MEMORIAL HOSP SCOTTSVILLE KY 42164	KY-11 *	328	11	8-17	4	50	6-81	10	40	10-63	5	0	2-69	21	24	11-47	11	45	15-67	38	16	6-33	44	7	8-32							
ARH REGIONAL MEDICAL CENTE HAZARD KY 41701	KY-12 *	1122	12	11-18	58	31	15-40	46	20	19-46	16	19	5-45	78	18	12-31	53	36	26-53	35	6	7-35	193	15	13-27							
BAPTIST HOSP E LOUISVILLE KY 40207	KY-13	2702	11	9-15	250	13	14-30	93	40	19-39	66	20	10-31	128	23	15-30	103	43	27-47	35	17	6-34	264	21	15-27							
BAPTIST HOSP HIGHLANOS LOUISVILLE KY 40204	KY-14	1356	12	9-16	105	36	21-41	28	32	14-47	15	27	7-50	52	15	14-37	31	29	24-58	28	25	7-39	95	21	15-33							
BAPTIST REG MED CTR CORBIN KY 40701	KY-15	1598	11	9-16	68	37	20-44	34	35	19-51	20	10	6-42	71	27	14-34	63	52	29-54	52	19	12-38	151	14	12-27							
BEREA HOSP BEREA KY 40403	KY-16	556	10	9-17	30	27	13-46	20	30	15-55	13	15	3-46	15	7	8-50	24	54	23-62	14	0	6-49	80	10	10-29							
BRECKINRIDGE MEMORIAL HOSP HARDINSBURG KY 40143	KY-17 *	491	13	11-19	29	55	19-54	33	27	17-48	9	0	2-53	28	29	11-42	15	47	17-63	15	20	7-50	95	8	12-30							
CALDWELL COUNTY HOSP PRINCETON KY 42445	KY-18	541	21	10-19	11	64	7-56	40	48	17-45	17	6	3-39	41	29	13-39	17	47	20-64	40	13	6-33	84	33	14-33							
CARROLL CO MEMORIAL HOSP CARROLLTON KY 41008	KY-19 *	338	11	8-17	4	25	7-82	19	32	10-49	8	13	4-60	14	21	7-49	5	40	9-79	27	7	4-34	72	11	10-30							
CASEY CO WAR MEMORIAL HOSP LIBERTY KY 42539	KY-20 *	194	12	8-19	5	60	6-76	13	38	11-58	4	0	2-74	5	0	4-72	4	50	8-83	7	29	5-65	40	15	10-36							
CAVERNA MEMORIAL HOSP HORSE CAVE KY 42749	KY-21 *	269	20	10-20	7	57	4-62	17	24	10-51	4	25	2-74	11	27	7-56	17	65	17-61	13	54	15-65	60	13	9-30							
CENTRAL BAPTIST HOSP-LEXINGTON KY 40503	KY-22 *	2482	11	9-15	225	20	16-31	89	26	19-38	53	11	8-32	92	27	17-36	82	40	29-52	40	5	7-34	228	20	14-27							
CLARK CO HOSP WINCHESTER KY 40391	KY-23 *	782	10	9-16	32	22	10-41	23	13	15-51	25	12	4-35	55	16	12-34	23	43	21-59	36	11	7-35	84	20	13-32							
CLINTON CO WAR MEM HOSP ALBANY KY 42602	KY-24 *	363	14	9-18	11	64	13-66	9	44	10-66	5	0	0-69	22	45	10-46	10	50	17-73	12	25	6-54	37	27	10-37							
COMMUNITY HOSP MAYFIELD KY 42066	KY-25 *	1169	14	10-17	62	37	19-44	48	44	17-43	21	10	5-39	68	25	15-36	51	47	28-56	17	18	8-48	146	17	14-30							
COMMUNITY UNITED METHODIST HENDERSON KY 42420	KY-26	1578	10	8-15	66	29	15-39	56	30	19-44	23	26	7-41	93	17	14-32	58	40	23-49	29	10	6-37	191	12	13-26							
CRITTENDEN CO HOSP MARION KY 42064	KY-27 *	417	19	15-25	4	0	4-78	14	36	13-60	12	25	4-49	35	14	12-41	44	52	33-63	29	7	14-48	71	38	13-34							
CUMBERLAND CO HOSP BURKESVILLE KY 42717	KY-28 *	395	10	11-20	5	40	18-89	11	27	12-63	4	25	2-75	25	28	13-47	14	57	24-72	17	6	5-44	51	18	16-41							
EPHRAIM MCDOWELL MEMORIAL DANVILLE KY 40422	KY-29 *	1254	11	7-14	84	30	14-36	30	27	12-43	18	28	5-41	52	31	14-37	34	38	22-54	19	21	5-42	138	17	12-28							
FLAGET MEMORIAL HOSP BAROSTOWN KY 40004	KY-30	447	17	10-19	13	8	7-53	19	58	11-50	16	38	6-46	31	35	11-40	34	29	23-55	36	14	8-36	49	18	10-33							
FLEMING CO HOSP FLEMINGSBURG KY 41041	KY-31 *	479	12	10-18	8	88	10-69	14	43	10-54	13	15	4-47	49	24	14-39	16	19	19-64	39	13	9-37	64	9	7-27							
FORT LOGAN HOSP STANFORD KY 40484	KY-32 *	353	14	9-18	8	25	6-62	11	18	9-58	4	0	1-74	21	19	7-41	12	50	16-67	13	31	5-50	63	27	13-34							
FRANKLIN SIMPSON MEMORIAL FRANKLIN KY 42134	KY-33 *	282	17	10-20	6	67	12-79	18	56	17-59	2	50	1-89	26	38	11-43	4	50	10-85	12	0	7-55	38	29	11-38							
GARRARD CO MEMORIAL HOSP-LANCASTER KY 40444	KY-34 *	284	14	10-21	14	36	12-59	10	20	10-62	4	0	1-74	10	30	5-54	15	33	17-63	20	10	5-41	50	22	12-36							
GOOD SAMARITAN HOSP-LEXINGTON KY 40508	KY-35	2252	10	8-15	156	28	20-38	98	24	19-38	33	9	7-36	89	22	14-32	60	37	27-52	64	17	10-33	166	22	13-27							
GRANT CO HOSP WILLIAMSTOWN KY 41097	KY-36 *	293	11	10-20	3	100	7-88	5	40	8-77	4	0	0-77	29	17	13-45	5	60	8-78	16	6	8-50	56	14	10-32							

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALLEN CO WAR MEMORIAL HOSP SCOTTSVILLE KY 42164	6	0	5-71	5	60	7-76	1	0	0-100	.	.		46	4	1-16	12	0	0-43	2	0	0-100	19	11	1-29	13	0	0-61
ARH REGIONAL MEDICAL CENTE HAZARD KY 41701	12	42	11-64	24	46	18-57	9	0	1-50	4	0	0-100	99	6	2-12	66	0	2-16	4	0	0-89	102	6	2-11	19	0	0-39
BAPTIST HOSP E LOUISVILLE KY 40207	16	13	8-54	27	22	16-53	94	5	4-17	30	0	0-56	351	4	2-8	149	9	3-13	34	0	0-42	189	3	2-9	176	4	0-6
BAPTIST HOSP HIGHLANDS LOUISVILLE KY 40204	12	25	7-58	10	50	16-72	39	10	3-23	1	100	0-100	83	6	2-14	55	11	2-17	7	0	0-78	98	7	2-12	42	2	0-16
BAPTIST REG MED CTR CORBIN KY 40701	10	60	11-67	37	30	21-54	53	4	3-20	1	0	0-100	212	7	2-9	119	4	3-15	16	0	0-98	193	3	3-9	70	1	0-10
BEREA HOSP BEREA KY 40403	7	43	9-72	9	22	12-70	18	0	1-32	.	.		74	4	1-13	25	0	1-27	5	0	0-100	60	2	2-14	20	0	0-37
BRECKINRIDGE MEMORIAL HOSP HARDINSBURG KY 40143	13	15	6-54	1	0	0-97	6	33	1-62	.	.		56	0	1-15	10	0	0-48	6	0	0-100	45	9	1-17	14	0	0-68
CALDWELL COUNTY HOSP PRINCETON KY 42445	7	43	9-72	3	100	8-89	22	0	2-29	.	.		38	16	1-18	19	32	1-32	3	0	0-100	45	4	1-17	24	0	0-36
CARROLL CO MEMORIAL HOSP CARROLLTON KY 41008	1	100	0-98	4	50	7-82	1	0	0-99	.	.		34	6	1-21	18	6	0-33	1	0	0-100	23	4	1-25	16	0	0-45
CASEY CO WAR MEMORIAL HOSP LIBERTY KY 42539	3	0	1-82	.	.		.	.		.	.		19	0	0-30	3	0	2-81	.	.		31	6	1-21	8	0	0-93
CAVERNA MEMORIAL HOSP HORSE CAVE KY 42749	3	100	5-86	3	67	5-86	3	33	0-88	.	.		20	5	0-29	4	25	0-89	.	.		29	7	0-21	6	17	0-98
CENTRAL BAPTIST HOSP-LEXINGTON KY 40503	47	26	9-42	10	60	18-74	79	6	3-17	10	0	0-99	230	4	3-10	130	4	1-11	29	0	0-90	248	6	3-9	188	1	0-5
CLARK CO HOSP WINCHESTER KY 40391	4	50	5-80	18	22	20-65	27	7	1-26	1	0	0-100	84	1	2-13	38	11	2-22	3	0	0-100	77	3	2-13	33	0	0-21
CLINTON CO WAR MEM HOSP ALBANY KY 42602	10	20	6-60	6	50	10-77	1	0	0-100	.	.		25	4	1-26	15	0	1-37	.	.		49	2	1-16	15	7	0-38
COMMUNITY HOSP MAYFIELD KY 42066	11	45	14-69	14	50	15-63	30	7	2-26	.	.		131	5	2-11	52	2	2-19	9	0	0-99	84	6	2-13	46	2	0-14
COMMUNITY UNITED METHODIST HENDERSON KY 42420	14	14	3-49	14	29	15-64	47	11	2-20	5	0	0-100	179	4	2-10	81	1	1-14	12	0	0-100	151	5	2-9	101	2	0-8
CRITTENDEN CO HOSP MARION KY 42064	16	25	7-53	12	42	24-76	1	100	0-97	.	.		30	7	2-24	7	0	0-60	.	.		33	0	1-20	8	0	0-94
CUMBERLAND CO HOSP BURKESVILLE KY 42717	11	0	9-62	3	33	7-88	1	0	0-99	.	.		37	5	1-20	14	0	1-38	.	.		55	4	2-16	12	0	0-56
EPHRAIM MCDOWELL MEMORIAL OANVILLE KY 40422	16	50	12-59	6	33	12-79	67	7	3-18	6	0	0-100	145	5	2-10	83	2	1-13	13	0	0-99	80	1	2-13	103	2	0-8
FLAGET MEMORIAL HOSP BAROSTOWN KY 40004	3	0	1-82	5	40	12-82	16	31	3-39	.	.		51	4	1-16	22	14	1-28	2	0	0-100	21	0	1-27	13	0	0-74
FLEMING CO HOSP FLEMINGSBURG KY 41041	5	60	6-76	10	50	17-72	4	0	0-81	.	.		38	8	2-22	15	7	1-37	.	.		30	0	1-21	16	0	0-47
FORT LOGAN HOSP STANFORD KY 40484	5	0	2-71	4	50	7-82	.	.		.	.		35	3	1-20	23	17	2-30	.	.		29	7	1-22	13	8	0-59
FRANKLIN SIMPSON MEMORIAL FRANKLIN KY 42134	12	42	11-63	2	0	4-92	.	.		.	.		24	0	0-25	7	0	1-58	.	.		25	8	1-25	5	0	0-98
GARRARD CO MEMORIAL HOSP-LANCASTER KY 40444	3	0	1-83	7	29	14-77	1	0	0-100				19	5	1-30	19	0	2-33	1	0	0-100	32	3	1-20	3	0	0-100
GOOD SAMARITAN HOSP-LEXINGTON KY 40508	23	17	11-52	18	39	20-64	78	8	5-20	90	1	0-10	207	6	3-10	82	10	2-14	21	0	0-46	148	3	2-9	177	2	0-5
GRANT CO HOSP WILLIAMSTOWN KY 41097	6	17	17-85	2	50	5-94	.	.		.	.		36	0	1-20	8	13	1-53	1	0	0-99	22	0	0-26	10	0	0-67

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																													
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease											
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent								
GRAYSON CO HOSP LEITCHFIELD KY 42754	KY-37 *	617	14	9-17	13	46	11-59	19	37	13-53	16	25	4-43	25	20	11-44	23	43	21-59	40	15	9-37	94	26	13-32								
GREENVIEW HOSP BOWLING GREEN KY 42101	KY-38 *	1761	10	8-15	108	31	16-36	50	34	18-44	25	8	4-34	63	16	13-34	47	45	25-54	39	15	14-44	182	18	13-27								
HARDIN MEMORIAL HOSP ELIZABETHTOWN KY 42701	KY-39 *	2219	13	10-16	107	14	14-33	78	18	19-39	26	19	7-39	150	16	17-31	63	46	27-52	69	35	12-36	293	29	17-30								
HARLAN APPALACHIAN REGIONA HARLAN KY 40831	KY-40 *	795	18	11-18	32	25	11-42	26	31	17-52	18	33	10-50	48	38	12-36	29	52	24-59	54	26	15-41	151	21	13-27								
HARRISON MEMORIAL HOSP CYNTHIANA KY 41031	KY-41	671	13	9-17	26	46	13-49	28	39	16-49	13	15	3-46	48	17	13-37	32	44	27-60	12	8	3-49	106	14	11-27								
HCA BOURBON GENERAL HOSP PARIS KY 40361	KY-42	430	12	9-18	18	17	9-49	16	6	9-50	11	18	7-56	38	18	13-40	19	42	21-64	12	17	4-50	46	13	7-30								
HCA KING'S DAUGHTERS MEMOR FRANKFORT KY 40601	KY-43 *	1084	13	9-16	44	27	18-46	48	33	19-45	23	22	5-38	76	32	15-34	44	43	24-53	52	25	9-34	121	17	11-27								
HCA LOGAN MEMORIAL HOSP RUSSELLVILLE KY 42276	KY-44 *	630	13	9-16	10	50	7-58	24	46	14-49	16	0	4-42	47	26	12-36	11	27	13-66	41	29	10-38	85	14	11-30								
HCA SCOTT GENERAL HOSP GEORGETOWN KY 40324	KY-45 *	312	18	10-20	16	25	7-48	13	23	12-59	6	33	7-72	17	18	9-49	19	63	24-67	18	28	4-42	37	35	12-40								
HIGHLANDS REGIONAL MEDICAL PRESTONSBURG KY 41653	KY-46	1249	11	9-16	36	31	13-42	22	32	14-52	40	18	8-35	73	30	13-32	40	48	24-54	42	10	8-35	250	13	12-24								
HUMANA HOSP AUDUBON LOUISVILLE KY 40217	KY-47	3336	11	8-14	192	29	18-35	101	21	17-35	58	16	8-30	136	21	15-30	146	39	27-45	64	9	8-30	307	15	12-24								
HUMANA HOSP LEXINGTON LEXINGTON KY 40509	KY-48	918	11	8-15	72	18	13-35	35	23	16-47	15	33	5-46	38	26	11-37	20	35	20-61	27	11	3-33	83	23	12-31								
HUMANA HOSP LOUISA LOUISA KY 41230	KY-49	588	16	9-17	14	43	10-56	24	42	16-53	17	18	5-44	44	36	13-38	35	46	20-51	25	12	6-39	68	24	10-30								
HUMANA HOSP SOUTHWEST LOUISVILLE KY 40272	KY-50	791	10	7-15	28	36	10-43	20	35	13-51	17	18	5-43	37	24	11-38	30	43	19-53	33	9	7-36	85	16	10-29								
HUMANA HOSP SUBURBAN LOUISVILLE KY 40207	KY-51	3214	9	7-13	226	18	15-31	92	36	18-38	65	14	8-30	118	20	16-33	107	29	27-47	62	23	10-34	294	18	13-25								
HUMANA HOSP UNIVERSITY LOUISVILLE KY 40202	KY-52	1535	12	8-15	110	23	19-39	41	27	13-40	39	26	11-39	74	23	11-30	46	43	21-49	43	16	8-34	108	18	11-28								
HUMANA HOSPITAL LAKE CUMBE SOMERSET KY 42501	KY-53	1793	14	10-17	124	32	18-38	72	32	20-42	24	33	7-40	81	32	15-35	117	46	30-50	84	12	11-33	212	17	13-27								
JAMES B HAGGIN MEMORIAL HO HARRODSBURG KY 40330	KY-54 *	483	14	9-18	30	47	15-49	16	38	12-55	8	63	8-66	21	14	9-44	23	52	21-60	21	10	10-48	54	19	11-33								
JANE TODD CRAWFORD MEMORIA GREENSBURG KY 42743	KY-55 *	245	16	8-19	9	44	14-72	10	50	10-63	7	14	3-61	10	20	6-57	5	60	12-82	B	38	3-58	32	38	12-42								
JENKINS COMMUNITY HOSP JENKINS KY 41537	KY-56 *	238	9	7-17	4	25	4-78	5	20	8-78	7	0	2-60	14	7	6-48	8	25	17-77	11	18	3-50	31	13	6-33								
JENNIE STUART MEDICAL CENT HOPKINSVILLE KY 42240	KY-57	1767	14	9-15	124	23	17-36	25	20	12-47	34	35	7-35	86	31	16-34	59	53	26-52	33	30	10-41	231	20	14-27								
JEWISH HOSP LOUISVILLE KY 40202	KY-58	3772	12	8-14	215	32	19-35	91	27	17-37	86	17	10-30	164	26	16-30	95	33	26-47	106	18	11-31	252	22	14-27								
KINGS DAUGHTERS HOSP ASHLAND KY 41101	KY-59	2263	11	9-15	156	33	19-37	78	37	19-40	46	15	9-33	143	21	15-30	63	46	26-51	77	14	9-30	242	11	13-26								
KNOX CO HOSP BARBOURVILLE KY 40906	KY-60	445	13	8-16	7	71	6-66	17	29	12-54	7	14	2-60	14	7	6-49	15	67	20-66	27	33	8-41	48	21	11-35								
LIVINGSTON CO HOSP SALEM KY 42078	KY-61	269	6	5-15	2	50	1-89	4	25	6-81	11	0	3-49	6	0	4-66	2	0	5-93	11	0	2-48	38	B	7-31								
LOURDES HOSP PADUCAH KY 42001	KY-62 *	3195	10	8-14	223	21	19-36	107	32	20-38	65	18	B-29	98	23	14-31	75	44	28-51	74	20	10-32	344	17	13-24								

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
GRAYSON CO HOSP LEITCHFIELD KY 42754	5	20	2-71	4	50	6-81	1	0	0-98	.	.		64	8	2-15	41	2	2-21	1	0	0-100	53	6	2-16	13	8	0-69			
GREENVIEW HOSP BOWLING GREEN KY 42101	18	6	5-48	24	33	20-59	60	8	3-20	8	0	0-99	215	2	3-10	68	12	2-16	18	0	0-97	163	1	2-9	147	3	0-6			
HARDIN MEMORIAL HOSP ELIZABETHTOWN KY 42701	33	30	12-48	29	41	19-55	56	13	4-22	14	0	0-99	225	4	3-9	157	8	3-13	34	0	0-20	163	2	2-9	118	2	0-7			
HARLAN APPALACHIAN REGIONA HARLAN KY 40831	6	33	5-71	10	50	13-69	19	26	2-33	1	0	0-100	103	7	2-12	44	7	1-19	2	0	0-100	52	10	1-15	13	8	0-77			
HARRISON MEMORIAL HOSP CYNTHIANA KY 41031	8	38	8-67	3	67	5-86	20	5	2-31	.	.		76	8	2-13	37	3	1-21	5	0	0-99	49	6	1-15	34	0	0-23			
HCA BOURBON GENERAL HOSP PARIS KY 40361	7	29	7-70	6	50	11-77	4	0	0-78	.	.		47	6	2-19	17	18	2-35	2	0	0-100	43	2	2-19	15	7	0-46			
HCA KING'S DAUGHTERS MEMOR FRANKFORT KY 40601	15	13	4-49	9	33	11-67	37	0	2-23	3	0	0-100	112	2	2-11	62	13	2-17	6	0	0-100	77	1	1-12	74	1	0-10			
HCA LOGAN MEMORIAL HOSP RUSSELLVILLE KY 42276	3	0	2-82	12	33	12-62	9	11	2-51	1	0	0-100	86	3	1-12	18	22	3-36	3	0	0-100	62	6	2-14	21	0	0-31			
HCA SCOTT GENERAL HOSP GEORGETOWN KY 40324	4	25	3-77	1	100	2-99	8	13	1-53	.	.		43	5	1-17	8	13	0-61	4	0	0-100	23	9	1-25	15	0	0-52			
HIGHLANDS REGIONAL MEDICAL PRESTONSBURG KY 41653	14	21	12-61	14	36	19-68	12	8	2-44	6	0	0-100	164	4	2-10	42	2	2-20	5	0	0-100	134	2	2-10	28	0	0-29			
HUMANA HOSP AUDUBON LOUISVILLE KY 40217	24	17	11-51	20	40	20-63	80	13	3-17	56	0	0-31	273	4	2-9	109	4	2-13	22	0	0-82	523	7	3-7	164	1	0-6			
HUMANA HOSP LEXINGTON LEXINGTON KY 40509	18	17	8-51	6	17	13-80	19	16	2-33	45	0	0-33	91	4	2-13	30	7	1-24	9	0	0-100	46	4	1-16	52	0	0-14			
HUMANA HOSP LOUISA LOUISA KY 41230	4	25	1-76	5	20	7-77	16	19	2-38	.	.		80	6	2-13	12	0	0-44	2	0	0-99	93	4	2-13	13	0	0-63			
HUMANA HOSP SOUTHWEST LOUISVILLE KY 40272	11	9	7-60	7	43	14-77	13	15	1-40	1	0	0-100	81	2	2-13	23	0	1-28	7	0	0-100	120	2	1-9	50	0	0-17			
HUMANA HOSP SUBURBAN LOUISVILLE KY 40207	24	13	11-51	14	36	17-66	120	7	4-15	71	0	0-19	311	2	2-7	134	3	1-11	32	0	0-54	201	5	2-8	297	1	0-4			
HUMANA HOSP UNIVERSITY LOUISVILLE KY 40202	17	35	6-50	18	67	17-61	41	15	3-22	17	0	0-93	91	9	3-15	41	7	1-19	10	0	0-93	127	5	2-10	50	0	0-16			
HUMANA HOSPITAL LAKE CUMBE SOMERSET KY 42501	6	50	2-67	10	40	13-68	60	12	3-20	1	0	0-100	210	6	3-10	89	6	2-15	25	0	0-90	134	1	2-10	62	3	0-12			
JAMES B HAGGIN MEMORIAL HO HARRODSBURG KY 40330	2	0	0-90	2	50	2-90	.	.	.	1	0	0-100	55	2	2-16	24	8	1-27	4	25	0-100	53	8	1-15	8	13	0-77			
JANE TODD CRAWFORD MEMORIA GREENSBURG KY 42743	1	0	0-99	3	33	7-88	.	.	.	.	.		45	4	1-17	13	8	1-40	2	0	0-100	17	6	2-34	7	0	0-90			
JENKINS COMMUNITY HOSP JENKINS KY 41537	6	33	7-74	2	50	3-91	.	.	.	.	.		25	4	1-26	5	0	0-90	1	0	0-100	43	9	1-17	7	0	0-73			
JENNIE STUART MEDICAL CENT HOPKINSVILLE KY 42240	16	13	5-50	13	38	13-62	63	8	3-19	3	0	0-99	244	8	3-9	109	2	1-12	19	0	0-99	107	4	2-10	66	6	0-11			
JEWISH HOSP LOUISVILLE KY 40202	77	22	8-36	63	21	23-50	69	14	3-18	97	0	0-9	296	5	3-10	124	6	4-16	14	0	0-60	657	5	3-7	274	0	0-4			
KINGS DAUGHTERS HOSP ASHLAND KY 41101	35	11	7-42	19	58	17-60	65	8	3-18	16	0	0-97	226	3	2-8	136	4	1-11	20	0	0-90	214	3	2-8	89	2	0-9			
KNOX CO HOSP BARBOURVILLE KY 40906	3	33	12-94	1	100	2-98	6	0	1-62	.	.		46	2	1-17	19	11	1-31	1	0	0-100	51	4	1-16	12	0	0-85			
LIVINGSTON CO HOSP SALEM KY 42078	5	20	4-74	3	67	4-85	.	.	.	.	.		49	4	1-16	14	0	1-38	3	0	0-100	22	5	0-26	5	0	0-96			
LOURDES HOSP PADUCAH KY 42001	41	29	13-48	25	48	21-59	92	12	3-17	21	0	0-95	355	6	3-8	121	1	1-12	31	0	0-42	203	3	3-9	247	1	0-4			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
MARCUM WALLACE MEMORIAL H IRVINE KY 40336	KY-63	250	15	8-18	7	71	9-70	8	38	8-65	4	0	1-75	19	42	10-48	5	40	12-82	22	0	7-43	40	28	8-34						
MARSHALL CO HOSP BENTON KY 42025	KY-64 *	409	13	9-18	17	29	7-48	9	33	7-61	14	7	3-44	33	27	13-42	19	79	24-67	10	10	5-56	53	15	10-33						
MARY &RECKINRIDGE HOSP HYDEN KY 41749	KY-65 *	231	10	9-19	7	57	12-75	4	0	4-77	3	0	3-83	13	23	8-53	4	25	9-84	5	20	2-69	40	13	8-34						
MARY CHILES HOSP MOUNT STERLING KY 40353	KY-66 *	605	15	11-19	31	48	15-48	21	29	12-50	15	20	7-49	23	26	12-48	29	28	21-55	24	17	10-45	91	22	11-29						
MARYMOUNT HOSP LONDON KY 40741	KY-67 *	751	14	9-17	26	38	13-49	24	42	18-54	16	25	5-45	43	26	13-38	34	56	24-56	31	13	9-40	66	21	12-33						
MCDOWELL APPALACHIAN REGIO MCDOWELL KY 41647	KY-68 *	316	8	7-16	6	67	10-76	9	44	11-66	8	13	4-59	10	30	8-60	3	100	8-90	16	6	3-42	49	2	8-31						
MCLEAN CO GENERAL HOSP CALHOUN KY 42327	KY-69 *	96	27	13-30	7	57	13-76	8	50	7-65	2	50	3-91	13	38	9-54	3	67	4-84	6	17	5-68	17	29	12-54						
MEADOWVIEW REGIONAL HOSP MAYSVILLE KY 41056	KY-70	907	13	10-17	43	23	10-37	36	28	16-46	18	28	8-47	48	27	13-37	48	40	27-55	64	16	9-32	97	12	10-27						
MEMORIAL HOSP MANCHESTER KY 40962	KY-71 *	531	14	10-18	12	58	15-67	21	38	13-51	7	29	4-63	21	38	12-49	6	50	13-79	35	9	10-40	87	22	14-33						
MERCY HOSPITAL OWENSBORO KY 42301	KY-72 *	1185	11	8-15	77	25	18-41	32	34	15-46	28	14	8-39	67	24	13-34	23	35	22-61	41	15	6-32	114	16	10-26						
METHODIST EVANGELICAL HOSP LOUISVILLE KY 40202	KY-73	2730	10	8-14	205	20	14-30	97	35	19-38	77	17	9-29	127	21	16-31	66	39	25-49	102	22	11-31	199	18	12-26						
METHODIST HOSP OF KENTUCKY PIKEVILLE KY 41501	KY-74 *	1716	13	8-15	88	35	17-39	62	44	20-43	19	16	6-43	68	32	14-35	53	53	24-51	43	9	8-35	245	16	11-23						
MIDDLESBORO APPALACHIAN RE MIDDLESBORO KY 40965	KY-75 *	673	12	9-17	32	53	20-54	13	31	13-61	10	20	5-55	28	43	13-46	20	55	20-61	50	8	7-31	89	15	11-29						
MONROE CO MEDICAL CTR TOMPKINSVILLE KY 42167	KY-76 *	376	11	6-15	5	80	6-75	5	20	4-72	8	13	2-56	21	19	8-42	8	38	13-72	17	0	4-43	66	23	9-29						
MORGAN CO APPALACHIAN REGI WEST LIBERTY KY 41472	KY-77 *	299	12	10-20	6	83	13-80	8	38	9-66	4	0	2-75	25	16	12-46	4	75	7-82	21	5	6-42	57	19	13-36						
MUHLENBERG COMMUNITY HOSP- GREENVILLE KY 42345	KY-78	848	16	9-16	38	61	18-49	36	56	16-45	21	33	4-38	48	27	13-38	25	52	24-62	20	25	7-44	131	18	11-27						
MURRAY-CALLOWAY CO HOSP MURRAY KY 42071	KY-79 *	1349	11	7-14	52	13	11-36	39	28	16-44	36	8	7-33	65	35	14-35	47	38	24-53	44	9	8-34	128	23	13-28						
NICHOLAS CO HOSP CARLISLE KY 40311	KY-80 *	262	10	9-19	8	63	11-70	6	33	6-70	1	0	0-99	8	0	5-60	6	17	10-76	22	14	6-42	22	9	10-46						
NORTON KOSAIR CHILDRENS HO LOUISVILLE KY 40202	KY-81	1913	8	7-14	200	16	20-37	31	29	15-47	36	17	8-35	43	9	12-38	38	34	23-54	23	13	7-42	116	21	12-28						
OHIO CO HOSP HARTFORD KY 42347	KY-82	577	18	9-17	27	59	17-52	23	35	14-50	7	29	1-58	28	39	12-44	23	65	18-56	16	31	3-42	69	22	11-31						
OUR LADY OF &ELLEFONTE HOS ASHLAND KY 41101	KY-83 *	1240	11	8-15	53	23	14-40	29	21	16-49	32	9	6-34	83	22	15-34	39	44	22-52	21	10	5-40	121	20	12-28						
OUR LADY OF THE WAY HOSP I MARTIN KY 41649	KY-84 *	374	10	7-15	5	60	10-81	11	45	12-64	7	14	1-59	18	17	8-46	10	50	15-70	14	14	6-50	64	8	7-26						
OWEN CO MEMORIAL HOSP OWENTON KY 40359	KY-85 *	223	17	9-20	1	0	1-97	10	60	9-61	1	0	0-99	14	29	7-49	8	50	15-75	9	11	2-53	42	17	10-36						
OWENSBORO OAVIESS CO HOSP OWENSBORO KY 42301	KY-86	2629	10	8-14	150	19	17-35	76	26	19-40	46	22	8-33	101	26	15-32	62	34	27-52	68	25	11-35	244	20	14-27						
PARKWAY REGIONAL HOSP FULTON KY 42041	KY-87 *	479	12	8-16	19	53	13-54	13	46	11-58	10	0	3-51	20	25	9-45	15	53	18-64	42	10	5-31	83	13	11-30						
PATTIE A CLAY INFIRMARY RICHMOND KY 40475	KY-88	1020	11	9-16	49	22	14-40	32	19	15-47	23	13	5-37	53	23	12-35	27	26	22-58	38	29	13-43	146	21	14-29						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
MARCUM WALLACE MEMORIAL H IRVINE KY 40336	.	.	.	.	.	.	1	0	0-100	1	0	0-100	11	0	0-44	7	0	1-57	.	.	.	29	3	1-22	7	0	0-84			
MARSHALL CO HOSP BENTON KY 42025	5	40	3-72	4	25	7-82	10	0	1-47	.	.	.	52	0	1-15	10	0	0-49	5	0	0-100	43	7	1-17	10	0	0-79			
MARY BRECKINRIDGE HOSP HYDEN KY 41749	3	0	1-82	8	50	10-70	1	0	0-100	.	.	.	18	11	2-34	10	10	1-47	1	0	0-100	38	0	1-19	4	0	0-98			
MARY CHILES HOSP MOUNT STERLING KY 40353	5	40	6-77	17	41	15-59	13	0	3-44	1	0	0-100	76	4	2-14	34	3	3-25	3	0	0-100	57	5	1-14	6	0	0-95			
MARYMOUNT HOSP LONDON KY 40741	7	14	6-68	11	45	14-67	19	0	1-31	.	.	.	78	5	3-15	35	11	2-24	7	0	0-96	64	6	1-13	20	0	0-37			
MCDOWELL APPALACHIAN REGIO MCDOWELL KY 41647	7	14	2-53	1	0	1-97	1	0	0-100	.	.	.	48	4	2-18	14	7	2-39	.	.	.	43	0	1-17	10	0	0-81			
MCLEAN CO GENERAL HOSP CALHOUN KY 42327	.	.	.	1	0	1-97	1	0	0-100	.	.	.	6	0	0-75	4	25	0-90	.	.	.	3	33	0-81	2	0	0-100			
MEADOWVIEW REGIONAL HOSP MAYSVILLE KY 41056	12	8	6-56	15	47	21-69	39	18	3-24	5	0	0-99	74	5	2-14	41	5	2-21	9	0	0-99	53	6	1-15	55	0	0-13			
MEMORIAL HOSP MANCHESTER KY 40962	4	50	7-83	7	43	8-70	11	18	1-44	1	0	0-100	66	8	2-15	24	8	4-33	3	0	0-100	54	2	1-14	9	0	0-63			
MERCY HOSPITAL OWENSBORO KY 42301	8	38	9-70	11	55	15-69	30	7	3-28	17	0	0-76	135	4	2-10	91	5	1-14	13	0	0-98	81	1	2-12	67	0	0-12			
METHODIST EVANGELICAL HOSP LOUISVILLE KY 40202	41	20	9-43	13	46	17-67	56	2	3-19	60	2	0-24	249	4	2-9	98	7	2-14	34	0	0-79	176	5	2-9	265	0	0-4			
METHODIST HOSP OF KENTUCKY PIKEVILLE KY 41501	13	46	5-53	14	43	15-63	45	11	2-21	12	8	0-95	207	4	2-9	150	3	2-12	13	0	0-93	188	4	2-9	63	2	0-12			
MIDDLESBORO APPALACHIAN RE MIDDLESBORO KY 40965	10	40	12-68	8	13	9-67	10	30	2-48	4	0	0-100	59	2	1-14	33	9	2-23	9	0	0-100	59	0	1-14	37	3	0-19			
MONROE CO MEDICAL CTR TOMPKINSVILLE KY 42167	1	0	0-98	.	.	.	1	0	0-99	.	.	.	42	5	1-17	21	14	1-29	.	.	.	21	5	1-27	23	0	0-28			
MORGAN CO APPALACHIAN REGI WEST LIBERTY KY 41472	.	.	.	1	0	2-98	.	.	.	.	.	.	23	0	1-26	24	21	4-34	.	.	.	27	0	1-23	2	0	0-96			
MUHLENBERG COMMUNITY HOSP- GREENVILLE KY 42345	7	14	5-68	5	0	7-76	23	9	1-28	.	.	.	101	5	2-12	44	7	1-19	7	0	0-100	60	5	1-13	33	0	0-25			
MURRAY-CALLOWAY CO HOSP MURRAY KY 42071	10	30	11-67	10	40	10-64	22	9	1-29	12	0	0-98	128	2	2-10	68	4	1-15	9	0	0-99	108	6	2-11	55	2	0-15			
NICHOLAS CO HOSP CARLISLE KY 40311	9	11	11-70	2	0	1-89	4	25	1-73	.	.	.	31	0	2-24	8	0	1-53	1	0	0-100	28	4	1-24	13	0	0-68			
NORTON KOSAIR CHILDRENS HO LOUISVILLE KY 40202	10	20	4-58	9	67	18-76	34	9	2-24	4	0	0-100	178	4	3-10	47	4	1-18	41	0	0-22	182	3	3-10	252	2	0-5			
OHIO CO HOSP HARTFORD KY 42347	10	20	4-57	7	57	14-77	15	0	1-36	1	0	0-100	78	5	2-14	47	9	1-18	7	0	0-95	63	8	2-14	20	0	0-44			
OUR LADY OF BELLEFONTE HOS ASHLAND KY 41101	14	21	8-56	9	44	19-77	18	22	2-34	5	0	0-100	133	3	2-11	86	5	2-14	4	0	0-100	128	4	2-10	30	0	0-34			
OUR LADY OF THE WAY HOSP I MARTIN KY 41649	7	29	5-67	3	33	6-87	.	.	.	.	.	.	51	0	1-15	9	0	1-50	2	0	0-100	67	3	1-12	4	0	0-100			
OWEN CO MEMORIAL HOSP OWENTON KY 40359	6	17	3-68	6	33	9-75	.	.	.	.	.	.	12	8	0-42	10	0	1-47	.	.	.	29	0	1-23	10	0	0-62			
OWENSBORO OAVIESS CO HOSP OWENSBORO KY 42301	21	24	9-51	15	47	16-63	77	5	3-18	31	0	0-45	264	5	3-9	154	5	2-11	28	0	0-50	220	5	3-9	161	1	0-5			
PARKWAY REGIONAL HOSP FULTON KY 42041	2	0	0-90	6	33	6-70	3	0	0-86	.	.	.	55	2	1-15	6	0	0-74	7	0	0-97	41	2	1-17	14	0	0-79			
PATTIE A CLAY INFIRMARY RICHMOND KY 40475	11	55	6-58	8	25	12-72	45	2	2-21	3	0	0-100	95	5	1-11	50	6	1-17	10	0	0-96	68	3	1-13	59	0	0-12			

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Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																													
					Cancer			Stroke			GI Catastrophes			Severe Chronic Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease												
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent								
PAUL B HALL REGIONAL MEDIC PAINTSVILLE KY 41240	KY-89 *	483	16	8-16	13	62	9-55	25	40	16-51	18	6	4-40	26	42	11-44	22	68	19-58	19	11	3-38	72	14	9-28								
PINEVILLE COMMUNITY HOSP- PINEVILLE KY 40977	KY-90 *	866	11	7-15	27	26	12-46	29	34	14-47	29	10	5-33	39	8	10-35	29	41	24-59	44	7	5-30	111	13	9-25								
RED BIRD MISSION HOSP- BEVERLY KY 40913	KY-91	23	17	3-32	.	.	.	1	100	2-99	.	.	.	1	100	0-97	.	.	.	.	.	.	8	0	2-55								
REGIONAL MEDICAL CENTER OF MADISONVILLE KY 42431	KY-92	2791	12	9-15	193	34	19-36	65	28	18-41	50	14	8-32	116	18	15-31	118	29	28-47	82	22	13-36	270	23	13-26								
ROCKCASTLE CO HOSP MOUNT VERNON KY 40456	KY-93 *	302	15	10-20	5	60	5-74	7	0	7-68	6	17	7-72	6	33	4-67	19	58	19-61	13	23	11-59	52	17	11-34								
RUSSELL CO HOSP RUSSELL SPRINGS KY 42642	KY-94 *	341	13	9-18	9	22	7-62	23	17	12-48	8	13	4-59	12	0	7-54	20	35	23-64	20	30	6-42	35	31	11-39								
SPRINGVIEW HOSP LEBANON KY 40033	KY-95	482	18	10-18	16	63	23-69	14	43	11-56	5	0	1-68	29	41	9-39	17	59	16-59	39	15	7-35	95	19	11-28								
SS MARY ELIZABETH HOSP LOUISVILLE KY 40215	KY-96	2820	12	9-15	157	22	15-32	99	37	20-38	43	14	9-35	171	23	16-29	115	50	29-48	82	20	10-32	280	16	12-24								
ST ANTHONY MEDICAL CENTER LOUISVILLE KY 40204	KY-97	2490	13	9-16	213	26	17-33	80	31	20-41	69	23	10-31	123	20	15-31	68	32	26-50	85	15	10-31	287	24	15-27								
ST CLAIRE MEDICAL CENTER MOREHEAD KY 40351	KY-98 *	1228	12	9-16	94	26	15-35	50	32	15-40	25	16	10-44	64	20	15-36	45	44	23-52	29	10	8-39	131	18	13-29								
ST ELIZABETH MEDICAL CENTE COVINGTON KY 41014	KY-99	4001	13	8-15	292	26	17-32	116	33	19-36	67	18	8-29	214	28	16-29	152	41	27-44	98	15	10-30	375	20	13-24								
ST JOSEPH HOSP LEXINGTON KY 40504	KY-100*	3911	11	9-15	319	18	20-35	124	17	19-36	48	25	10-35	185	34	18-32	142	38	29-47	62	23	13-38	188	21	14-28								
ST LUKE HOSP FORT THOMAS KY 41075	KY-101	2273	13	9-16	212	27	18-34	78	26	19-39	52	17	9-32	114	25	15-32	81	49	28-50	46	13	8-34	219	23	14-27								
T J SAMSON COMMUNITY HOSP GLASGOW KY 42141	KY-102	1767	13	9-16	73	27	16-39	69	35	19-41	24	29	7-40	93	24	16-34	86	45	29-51	58	26	11-36	214	18	13-26								
TAYLOR CO HOSP CAMPBELLSVILLE KY 42718	KY-103	756	12	8-15	50	24	12-38	6	33	4-67	21	5	5-39	28	32	11-42	26	23	20-56	23	26	7-41	65	18	13-35								
THE MEDICAL CENTER AT BOWL BOWLING GREEN KY 42101	KY-104	1581	14	9-16	89	24	19-41	57	25	17-41	22	36	10-46	58	19	13-35	61	54	27-52	58	22	10-34	192	22	15-29								
TRIGG CO HOSP CADIZ KY 42211	KY-105*	264	15	8-18	7	29	7-68	11	27	13-65	11	9	2-48	11	36	8-57	9	44	13-70	19	26	5-42	24	29	8-41								
UNITED MEDICAL CTR SHELBYV SHELBYVILLE KY 40065	KY-106*	816	17	9-17	33	27	10-40	34	41	17-47	29	21	6-36	36	39	13-42	30	50	25-60	22	32	10-47	109	29	15-33								
UNIVERSITY HOSP LEXINGTON KY 40506	KY-107	1714	13	10-16	173	18	22-40	53	23	18-43	37	41	13-42	42	26	12-37	45	33	24-53	54	26	11-37	96	36	14-32								
US ARMY HOSP FORT KNOX KY 40121	KY-108	2	50	0-98	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.								
VALLEY VIEW MEDICAL CENTER MORGANFIELD KY 42437	KY-109*	245	11	10-20	10	10	9-63	9	22	8-62	9	22	12-69	14	29	6-49	14	36	21-69	7	29	2-60	20	5	6-41								
WAYNE CO HOSP INC MONTICELLO KY 42633	KY-110	233	15	10-20	14	71	13-60	6	0	10-76	4	0	0-77	13	38	9-55	1	0	3-99	16	50	9-52	50	14	10-33								
WESTERN BAPTIST HOSP PADUCAH KY 42001	KY-111	3043	11	8-14	183	34	20-37	94	30	20-39	47	17	6-30	109	28	15-31	99	39	27-47	54	19	8-32	285	17	13-25								
WESTLAKE CUMBERLAND HOSP COLUMBIA KY 42728	KY-112*	584	10	7-15	7	14	7-67	7	14	10-71	6	0	2-64	28	29	12-44	12	42	18-70	27	30	10-44	50	16	10-33								
WHITESBURG APPALACHIAN REG WHITESBURG KY 41858	KY-113*	680	13	10-18	12	42	12-62	23	9	13-50	23	17	5-38	49	24	13-38	41	39	24-54	29	7	7-38	91	23	13-31								
WILLIAM BOOTH MEMORIAL HOS FLORENCE KY 41042	KY-114	1304	11	8-15	74	23	16-39	36	28	18-48	32	25	8-37	58	24	12-34	44	48	26-55	23	13	7-42	144	15	12-27								

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
PAUL B HALL REGIONAL MEDIC PAINTSVILLE KY 41240	4	50	3-77	3	100	6-87	4	25	1-74	2	0	0-100	57	2	1-14	30	0	1-23	3	0	0-100	57	11	1-14	17	0	0-68
PINEVILLE COMMUNITY HOSP- PINEVILLE KY 40977	9	22	2-57	12	58	15-67	7	0	0-65				98	4	1-11	46	4	1-19	9	0	0-96	73	16	1-12	33	3	0-26
RED BIRD MISSION HOSP- BEVERLY KY 40913	.			.									4	0	0-90	1	0	0-98							1	0	0-100
REGIONAL MEDICAL CENTER OF MADISONVILLE KY 42431	21	24	9-51	24	42	17-56	89	11	3-17	40	0	0-32	262	6	3-10	137	7	3-13	7	0	0-100	240	5	2-8	162	0	0-6
ROCKCASTLE CO HOSP MOUNT VERNON KY 40456	5	0	2-71	8	38	12-73	2	0	1-89	.			32	6	1-22	12	0	1-42	2	0	0-100	39	5	1-19	5	0	0-99
RUSSELL CO HOSP RUSSELL SPRINGS KY 42642	2	0	1-90	.	.		2	50	0-89				25	4	1-24	15	20	1-36	8	0	0-100	34	0	1-20	16	0	0-52
SPRINGVIEW HOSP LEBANON KY 40033	12	33	7-58	.	.		.						61	2	1-14	14	14	2-39	1	0	0-100	37	3	1-18	13	8	0-42
SS MARY ELIZABETH HOSP LOUISVILLE KY 40215	26	31	11-50	23	39	18-58	70	10	4-20	26	0	0-56	285	5	3-9	114	4	2-13	22	0	0-46	314	4	3-8	155	1	0-6
ST ANTHONY MEDICAL CENTER LOUISVILLE KY 40204	25	28	10-50	20	30	18-61	60	7	4-20	11	0	0-98	284	6	3-9	127	6	3-15	12	0	0-85	148	4	2-9	151	0	0-6
ST CLAIRE MEDICAL CENTER MOREHEAD KY 40351	9	33	5-61	9	56	15-73	40	5	3-23	1	0	0-99	110	3	2-11	80	5	1-14	14	0	0-46	83	5	2-13	48	2	0-16
ST ELIZABETH MEDICAL CENTE COVINGTON KY 41014	31	32	14-51	69	39	22-48	115	3	3-15	25	0	0-63	363	3	3-8	187	8	2-12	21	0	0-92	350	5	2-7	226	0	0-5
ST JOSEPH HOSP LEXINGTON KY 40504	39	21	13-48	24	42	19-59	69	4	3-18	76	0	0-16	347	7	4-10	149	3	1-11	11	0	0-94	563	6	4-8	257	2	0-5
ST LUKE HOSP FORT THOMAS KY 41075	25	16	11-51	26	46	20-58	62	5	3-18	18	0	0-56	243	4	3-9	78	6	2-15	12	0	0-97	188	7	2-9	147	2	0-6
T J SAMSON COMMUNITY HOSP GLASGOW KY 42141	12	25	5-55	13	77	17-67	85	5	4-18	2	50	0-100	208	6	3-10	93	1	1-13	15	0	0-90	122	7	2-10	95	1	0-9
TAYLOR CO HOSP CAMPBELLSVILLE KY 42718	6	50	2-67	4	100	6-80	27	4	2-27	20	0	0-93	90	4	2-12	79	1	2-15	8	0	0-100	49	2	1-16	17	0	0-38
THE MEDICAL CENTER AT BOWL BOWLING GREEN KY 42101	12	42	6-56	29	34	18-54	64	6	2-18	5	0	0-100	124	8	2-11	103	9	2-14	8	13	0-68	122	3	2-10	95	1	0-8
TRIGG CO HOSP CADIZ KY 42211	5	40	1-71	1	0	1-97	1	0	0-100	2	0	0-100	31	3	1-21	4	25	0-76	.	.		27	0	1-23	6	0	0-99
UNITED MEDICAL CTR SHELBYV SHELBYVILLE KY 40065	7	43	7-70	8	50	14-74	26	15	2-28	1	0	0-100	102	3	2-12	34	6	1-22	6	0	0-100	67	6	1-13	42	2	0-17
UNIVERSITY HOSP LEXINGTON KY 40506	64	8	5-35	7	71	14-77	26	15	4-31	34	0	0-33	117	9	4-15	61	13	2-16	15	0	0-54	118	5	2-11	105	1	0-8
US ARMY HOSP FORT KNOX KY 40121		.		.	.					.	.														.	.	
VALLEY VIEW MEDICAL CENTER MORGANFIELD KY 42437	3	0	1-82	3	33	6-87							22	9	1-28	5	0	1-67	1	0	0-100	27	4	1-24	9	11	1-49
WAYNE CO HOSP INC MONTICELLO KY 42633	3	100	14-95	2	0	3-91	3	0	0-93				26	0	0-24	5	0	2-69	.	.		15	0	0-35	9	0	0-98
WESTERN BAPTIST HOSP PADUCAH KY 42001	23	9	8-48	13	54	16-66	83	18	3-17	19	0	0-80	312	4	2-8	126	5	1-12	39	0	0-29	395	2	3-8	187	1	0-5
WESTLAKE CUMBERLAND HOSP COLUMBIA KY 42728	5	20	4-74	5	20	9-80	6	0	1-62	1	0	0-100	68	4	2-14	30	17	3-26	5	0	0-100	42	5	1-17	23	0	0-38
WHITESBURG APPALACHIAN REG WHITESBURG KY 41858	6	17	3-68	10	50	18-74							81	5	1-12	19	11	1-32	3	0	0-100	93	3	1-11	16	0	0-73
WILLIAM BOOTH MEMORIAL HOS FLORENCE KY 41042	17	12	6-49	19	42	21-65	42	5	2-21	2	0	0-100	135	4	2-10	48	6	1-18	4	0	0-100	109	2	2-11	92	3	0-8

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																													
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease											
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent								
WILLIAMSON APPALACHIAN REG SOUTH WILLIAMSON KY 41503	KY-115*	695	11	8-15	30	47	21-56	18	39	11-52	14	7	4-45	24	21	10-44	31	45	24-58	26	8	5-37	84	14	8-26								
WOODFORD MEMORIAL HOSP VERSAILLES KY 40383	KY-116*	378	15	7-16	23	48	9-45	8	50	6-62	10	0	2-50	19	26	8-44	13	38	15-63	15	20	5-46	41	22	10-35								

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WILLIAMSON APPALACHIAN REG SOUTH WILLIAMSON KY 41503	2	50	1-90	3	67	6-88	9	0	0-52	1	0	0-100	99	4	2-12	32	3	1-22	3	0	0-100	78	3	2-13	23	4	0-27
WOODFORD MEMORIAL HOSP VERSAILLES KY 40383	7	14	5-66	3	100	3-84	19	5	1-32		.		50	4	2-17	22	5	0-30	2	0	0-98	21	5	0-27	8	0	0-87

*Written Comments Not Submitted.

COMMENTS ON HCFA MORTALITY DATA
BAPTIST HOSPITAL EAST
Louisville, Ky. 40207

Provider Number: 180130

DATA VERIFICATION

The data used by HCFA indicate that a total of 2,702 Medicare patients were admitted to Baptist Hospital East in 1986; of that total 302 patients died within 30 days of admission to the hospital. Of these 248 died while still patients while 54 died after discharge. Our own records indicate that 4,104 Medicare admissions occurred in 1986. Presumably the discrepancy in the number of "admissions" and number of "patients" reflects multiple admissions of individual beneficiaries. Baptist Hospital East has no way of verifying whether the number of Medicare beneficiaries treated at BHE is correct.

The HCFA data state that 54 patients died after discharge from this hospital; our information indicate that 4 of those actually died in our Emergency Room. Information concerning the status of patients after discharge is not contained in the patient's medical record and therefore, it is not possible for us to verify this information.

Without detailed information concerning the billing data available to HCFA in the computing of the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the HCFA analysis.

INTERPRETIVE REMARKS

Of the 50 patients who died after being discharged, our records indicate that death was expected to occur in 49 of these cases due to the advanced stage of the patients' diseases and their generally debillitated state. Of these 49 patients 23 were discharged to the care of nursing homes, at least 1 was to be cared for by Hospice, and 1 was transferred to another hospital.

In one instance this hospital exceeded the range of HCFA's predicted mortality rates. The HCFA data attribute Baptist Hospital East with 93 Medicare patients with cerebrovascular accident listed as the principal diagnosis when our own records reflect that there were 163 Medicare admissions with this principal diagnosis. HCFA data indicate a 40% mortality rate for these patients while our data shows a 23% rate, clearly within the range of predicted mortality rates. Again, it is not possible for us to evaluate fully this data without the benefit of the information used by HCFA.

It should be noted that a fair number of our Medicare patients who expired while inpatients either personally on admission or later per family member requested that no heroic measures be taken or CODE called due to the extensive disease processes and debillitated condition.

As part of the ongoing Quality Assurance Program at Baptist Hospital East mortality records are reviewed monthly by the medical staff to determine the quality of care.

HOSPITAL = 180130 BAPTIST HOSP E LOUISVILLE KY

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	2,702	11 %	9 TO 15 %
CA - CANCER	250	13 %	14 TO 30 %
CE - CEREBROVASCULAR ACCIDENTS	93	40 %	19 TO 39 %
EY - OPHTHALMOLOGIC DISEASE	30	0 %	0 TO 56 %
GC - GASTROINTESTINAL CATASTROPHES	66	20 %	10 TO 31 %
GI - GASTROINTESTINAL DISEASE	351	4 %	2 TO 8 %
GU - UROLOGIC DISEASE	149	9 %	3 TO 13 %
GY - GYNECOLOGIC DISEASE	34	0 %	0 TO 42 %
HL - LOW-RISK HEART DISEASE	189	3 %	2 TO 9 %
HM - SEVERE CHRONIC HEART DISEASE	128	23 %	15 TO 30 %
HS - SEVERE ACUTE HEART DISEASE	103	43 %	27 TO 47 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	35	17 %	6 TO 34 %
OP - ORTHOPEDIC DISORDERS	176	4 %	0 TO 6 %
PN - PULMONARY DISEASE	264	21 %	15 TO 27 %
RN - RENAL DISEASE	16	13 %	8 TO 54 %
SE - SEPSIS	27	22 %	16 TO 53 %
TR - SEVERE TRAUMA	94	5 %	4 TO 17 %

COMMENTS ON HCFA MORTALITY DATA
BAPTIST HOSPITAL HIGHLANDS
Louisville, Ky. 40204

Provider Number: 180100

DATA VERIFICATION

The data used by HCFA indicate that a total of 1356 Medicare "patients" were admitted to Baptist Hospital Highlands in 1986; of that total, 157 Medicare patients died within 30 days of admission to the hospital. Of these 118 died while still patients while 39 died after discharge. Our own records indicate that 2546 Medicare admissions occurred in 1986. Presumably the discrepancy in the number of "admissions" and number of "patients" reflects multiple admissions of individual beneficiaries. Baptist Hospital Highlands has no way of verifying whether the number of Medicare beneficiaries treated at this hospital is correct.

The HCFA data state that 39 of these 157 patients died after discharge from this hospital; information concerning the status of patients after discharge is not contained in the patient's medical record and therefore it is not possible for us to verify this information.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the HCFA analysis. Additionally, the principal diagnosis recorded on the bill and presumably used by HCFA in this analysis is not always indicative of the cause of death.

INTERPRETATIVE REMARKS

Of the 39 patients who died after being discharged, our records indicate that death was expected to occur in 28 of these cases due to the advanced stage of the patients' diseases and their generally debillitated state. Of these 28 patients 9 were discharged to the care of nursing homes and at least 3 were to be cared for by Hospice. Of the 118 who died while patients, death was expected in at least 50% of the cases due to the patients' disease and the condition of the patient on discharge.

In no instances does this hospital exceed the range of HCFA predicted mortality rates. It should be noted that we have an Oncology Unit which aggressively treats many cancer patients. In at least 20 cases HCFA attributed the patients' death to another cause besides cancer; in fact these 20 patients had wide spread metastatic disease even though the immediate cause of death could have been due to another factor. The HCFA data attribute Baptist Hospital Highlands with 105 Medicare patients in the "cancer" diagnostic category when our own records reflect that there were 390 Medicare Oncology admissions to this hospital. Again since many of these patients had multiple admissions to this and other hospitals it is not possible for us to evaluate fully this HCFA data.

Because verification of deaths occurring after discharge is not generally possible, the one ophthalmologic disease death which is attributed to us cannot be confirmed or denied. This particular patient was not generally in good health, however on discharge from this hospital the patient was alive.

It should be noted that the Medical Staff of this hospital reviews all of the medical records of patients who die while inpatients; this is one part of the on-going Quality Assurance program of Baptist Hospital Highlands.

HOSPITAL = 180100 BAPTIST HOSP HIGHLANDS LOUISVILLE KY

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	1,356	12 %	9 TO 16 %
CA - CANCER	105	36 %	21 TO 41 %
CE - CEREBROVASCULAR ACCIDENTS	28	32 %	14 TO 47 %
EY - OPHTHALMOLOGIC DISEASE	1	100 %	0 TO 100 %
GC - GASTROINTESTINAL CATASTROPHES	15	27 %	7 TO 50 %
GI - GASTROINTESTINAL DISEASE	83	6 %	2 TO 14 %
GU - UROLOGIC DISEASE	55	11 %	2 TO 17 %
GY - GYNECOLOGIC DISEASE	7	0 %	0 TO 78 %
HL - LOW-RISK HEART DISEASE	98	7 %	2 TO 12 %
HM - SEVERE CHRONIC HEART DISEASE	52	15 %	14 TO 37 %
HS - SEVERE ACUTE HEART DISEASE	31	29 %	24 TO 58 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	28	25 %	7 TO 39 %
OP - ORTHOPEDIC DISORDERS	42	2 %	0 TO 16 %
PN - PULMONARY DISEASE	95	21 %	15 TO 33 %
RN - RENAL DISEASE	12	25 %	7 TO 58 %
SE - SEPSIS	10	50 %	16 TO 72 %
TR - SEVERE TRAUMA	39	10 %	3 TO 23 %

Baptist
Regional Medical Center

1 Trillium Way
Corbin, Kentucky 40701

Kerry Gillihan
Chief Executive Officer
(606) 528-1212.

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Dept. of Health and Human Services
Washington, D.C. 20201

RE: Medicare Mortality Report - **Medicare Provider #180080**

Dear Dr. Roper:

Fortunately I am pleased to find that the Medicare patients mortality rates at the Baptist Regional Medical Center (BRMC) are well within the normal and expected ranges. The medical staff and hospital staff at BRMC work diligently to promote the most beneficial and appropriate level of health services to our region. It is particularly encouraging to find that our rate is very good compared to the national average given that our percentage of medicare patients treated is fairly high.

However, please permit me to comment briefly on the reporting of these mortality data. It is discouraging that such statistics are published nationally and publicly. I'm not certain of the original intent of such an action, because it surely has the potential to cause a great amount of confusion and misinterpretation by the public. Consequently, many readers may lose confidence in their healthcare institutions and physicians if some of their area mortality statistics are beyond the expected ranges.

I would like to encourage you to perhaps redirect such a potentially alarming dissemination of information. As a health care provider I can appreciate it's usefulness to hospitals. However, I believe it may be harmful to some readers.

Cordially,

Kerry Gillihan

Kerry G. Gillihan
Chief Executive Officer

KEG/fa

Cruelty close to home

Berea Hospital, Inc.

Administrator, David E. Burgio, F.A.C.H.E.

P.O. Box 128 • Berea, Kentucky 40403 • 606-986-3151

October 13, 1987

William L. Roper, M.D., Administrator
Dept. of Health & Human Resources
Washington, DC 20201

RE: Mortality Rate
Berea Hospital #180055

Dear Dr. Roper:

This letter is in response to the published mortality report for Berea Hospital and the request for comments.

Of the 58 deaths listed for our facility as discharged and expired within 30 days, there were eleven (11) that should be further explained. Nine (9) were transferred to our Skilled Nursing Facility and two (2) were transferred to other health care providers where they expired. These should not be classified as hospital deaths.

The following is a detailed analysis of these cases:

PT. ID #	SURNAME	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	DISPOSITION
[redacted]	[redacted]	05/22/86	06/03/86	06/11/86	SNF
		07/04/86	07/15/86	07/31/86	SNF
		03/09/86	03/13/86	03/17/86	SNF
		11/21/86	11/26/86	12/08/86	SNF
		02/07/86	02/14/86	03/05/86	SNF
		08/29/86	09/05/86	09/20/86	SNF
		11/15/86	11/25/86	12/15/86	SNF
		01/15/86	01/24/86	02/03/86	BHCC*
		02/11/86	02/18/86	03/02/86	VA HOSPITAL
		08/31/87	09/05/86	09/27/86	SNF
		04/30/86	05/09/86	05/14/86	SNF

*BEREA HEALTHCARE CENTER

Another patient [redacted] was admitted on 02/11/8 discharged on 02/12/86, and expired 02/18/86 according to your report. Actually, this patient expired in Berea Hospital on 02/12/86.

We hope these brief comments have been helpful to you.

Thank you.

Very truly yours,

David E. Burgio, FACHE
Administrator

DEB/lkc

cc: Cherif E. Hechema, M.D.
Chief of Staff

CALDWELL COUNTY HOSPITAL, INC.
P. O. BOX 410 - 101 HOSPITAL DRIVE
PRINCETON, KENTUCKY 42445
PHONE (502) 365-0300

October 26, 1987

Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Sirs:

The mortality data we have received by HCFA indicates that a total of 114 Medicare patients admitted to Caldwell County Hospital died within 40 days of admission. Of these, 84 died while still a patient of the hospital, while 30 died after discharge. Our own records indicate that 919 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Caldwell County Hospital is correct. It is impossible to determine the percentage of the 30 patients dying after discharge who were in fact alive, as information concerning death after discharge in not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis. We do not agree with your methods of calculations due to the fact that patients are grouped in categories of principal final diagnosis and not grouped by cause of death.

In the 3 categories that exceeded the HCFA predicted range of mortality rates, all charts of inpatients whose deaths occurred within this facility contained "Do Not Resusitate" orders with an average age of 76.7 years. The "Do Not Resusitate" orders were at the wish of the patient and/or their family.

We would also like to point out that due to a shortage of nursing home beds in our area of the state, many patients with chronic illnesses are cared for within the home and enter our facility shortly before death for acute hospital care.

Thank You.

Sincerely,

Jeffery L. Buckley, Administrator

COMMUNITY METHODIST HOSPITAL

October 16, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Please accept the enclosed data and comments as a public record of the Community Methodist Hospital in Henderson, Kentucky in reference to the HCFA Mortality Data. I am

Respectfully yours,

John A. Logan, III, M.D.
Medical Director

JAL:lp

enclosure

1305 N. Elm St. - Henderson, Kentucky 42420 - Ph. (502)826-6251
KY 26

HCFA MORTALITY DATA VS. COMMUNITY METHODIST HOSPITAL DATA

ETIOLOGY	DEATHS IN-PTS	DEATHS POST-DISCHARGE	PRINCIPAL DIAGNOSIS CMH	PRINCIPAL DIAGNOSIS HCFA	MORTALITY % CMH	MORTALITY % HCFA	PREDICTED RANGE
ALL CAUSES	118	49	2449	1578	6.81	10	8-15 %
(16 Specific causes)	118	49	2044	1578	8.1	10	8-15
CANCER	16	5	78	66	26.9	29	15-39
CEREBROVASCULAR ACCIDENTS	13	3	170	56	28.5	30	19-44
OPHTHALMOLOGIC	0	0	7	5	0	0	0-100
GASTROINTESTINAL CATASTROPHES	0	0	87	23	5.7	26	7-41
GASTROINTESTINAL DISEASE	0	0	216	179	0	4	2-10
UROLOGIC DISEASE	0	0	138	81	0	1	1-14
GYNECOLOGIC DISEASE	0	0	8	12	0	0	0-100
LOW-RISK HEART DISEASE	0	0	82	151	0	5	2-9
SEVERE CHRONIC HEART DISEASE	3	6	236	93	3.8	17	14-32
SEVERE ACUTE HEART DISEASE	61	6	280	58	23.9	40	23-49
METABOLIC/ELECTROLYTE DISTURBANCE	5	0	159	29	.031	10	6-37
ORTHOPEDIC DISORDERS	0	0	227	101	0	2	0-8
PULMONARY DISEASE	31	11	348	191	12.3	12	13-26
RENAL DISEASE	5	1	(SEE GU)	14	-	14	3-49
SEPSIS	6	0	30	14	20.0	29	15-64
TRAUMA	1	0	(SEE ORTHO)	47	-	11	2-20

* HCFA - HEALTH CARE FINANCING ADMINISTRATION

* CMH - COMMUNITY METHODIST HOSPITAL - HENDERSON, KENTUCKY

ETIOLOGY	# DRG IN CATEGORY
CANCER	10-11, 64, 82, 172, 199, 203, 239, 257-260, 274-275, 338, 344, 354, 355, 357, 363, 366, 367
CEREBROVASCULAR ACCIDENTS	14-17, 22
OPHTHALMOLOGIC	36-48
GASTROINTESTINAL CATASTROPHES	148-149, 174-176, 180, 191-202
GASTROINTESTINAL DISEASE	66, 68, 70, 78, 146-149, 150, 154, 157, 158, 159, 160, 161, 162, 177, 179, 182, 183, 185, 187
UROLOGIC DISEASE	302-333
GYNECOLOGIC DISEASE	353-369
LOW-RISK HEART DISEASE	110, 112-114, 120, 128, 130, 131, 136, 143-145
SEVERE CHRONIC HEART DISEASE	116, 118, 132-135, 138-140
SEVERE ACUTE HEART DISEASE	121-125, 127, 129, 141, 142
METABOLIC/ELECTROLYTE DISTURBANCE	193, 195, 198, 204, 205, 207, 208, 292, 294, 296, 297, 301
ORTHOPEDIC DISORDERS	209=256
PULMONARY DISEASE	75-102
RENAL DISEASE	SEE UROLOGIC (GU)
SEPSIS	415-423
SEVERE TRAUMA	SEE ORTHOPEDIC

HCFA DATA UTILIZES ICD-9 CODES, WHEREAS, CMH DATA USES DRG CODES.

HCFA DATA UTILIZES PRINCIPAL DIAGNOSIS IN COMPUTING MORTALITY RATES, WHEREAS, CMH DATA UTILIZES THE ACTUAL CAUSE OF DEATH AS NOTED ON THE PATIENT'S MEDICAL RECORD.

HCFA DATA DOES NOT SEEM TO REFLECT ANY WEIGHT AS TO THE SEVERITY OF ILLNESS.

HCFA DATA REFLECTS ONLY THE LAST ADMISSION OF THE PATIENT TO ANY HOSPITAL DURING 1986, THEREBY, NOT CONSIDERING ANY PREVIOUS ADMISSION TO OUR HOSPITAL DURING 1986. (REMOVES DATA OF OUR HOSPITAL AND ALSO ALL TRANSFERS.)

HCFA DATA IS LIMITED TO SIXTEEN DISEASE CATEGORIES, WHICH IS ESTIMATED TO ACCOUNT FOR APPROXIMATELY 70-80% OF THE MEDICARE ADMISSIONS NATIONWIDE.

FOURTEEN OUT-OF-HOSPITAL DEATHS COULD NOT BE VERIFIED BY CMH.

AT LEAST ONE OUT-OF-HOSPITAL DEATH WAS ATTRIBUTED TO SUICIDE.

ALL CMH DEATHS HAVE HAD INTERNAL REVIEW OF THE APPROPRIATE MEDICAL COMMITTEES.

PRIOR TO JULY 1, 1986, EXTERNAL DEATH REVIEW WAS CONDUCTED BY KPRO. SINCE JULY 1, 1986, 100% OF ALL DEATH CHARTS HAVE HAD REVIEW BY PEERVIEW, THE STATE REVIEW ORGANIZATION WHO HOLDS THE CONTRACT WITH HCFA TO ASCERTAIN QUALITY OF CARE FOR MEDICARE PATIENTS.

PEERVIEW HAS FURNISHED CMH WITH DATA WHICH STATES THE MORTALITY RATE FOR THE INSTITUTION FROM JULY 1, 1986 THROUGH JULY 31, 1987 WAS 6.22%.

IN ACCESSING THE HCFA DATA, ONE MUST REALIZE THE MANY COMPLEXITIES WHICH ARE INHERENT IN THE DATA:

KY 26.3

A- NO WEIGHT GIVEN TO THE SEVERITY OF ILLNESS.

B- THE USE OF THE PRINCIPAL DIAGNOSIS AND NOT THE ACTUAL CAUSE OF DEATH LIMITS THE USEFULNESS OF THE DATA, SINCE THE PRINCIPAL DIAGNOSIS AND THE CAUSE OF DEATH MAY OR MAY NOT BE THE SAME.

C- EACH TIME A MEDICARE PATIENT IS ADMITTED TO A HOSPITAL WITH ANY ONE OF THE ABOVE DIAGNOSES, THE PREDICTED CHANCE OF DEATH IS PRESENT. BY USING ONLY THE LAST ADMISSION IN THE CALENDAR YEAR, THE PERCENTAGE PROBABILITY OF A DEATH OCCURRING ON ALL PREVIOUS ADMISSIONS DURING THE CALENDAR YEAR IS TOTALLY IGNORED.

THE MORTALITY DATA AS SUPPLIED BY HCFA REFLECTS THAT THE DEATH RATE IN THIS INSTITUTION IS WITHIN THE PREDICTED RANGE FOR ALL CAUSES AS WELL AS WITHIN THE PREDICTED RANGE IN EACH DISEASE CATEGORY. HOWEVER, THE ACTUAL MORTALITY PERCENTAGE IS ACTUALLY LOWER IN ALMOST ALL CATEGORIES WHEN ACTUAL CAUSE OF DEATH AS WELL AS CLASSIFICATION UTILIZING DRGs INSTEAD OF ICD-9 CODES ARE CONSIDERED.

HOSPITAL = 180056 COMMUNITY UNITED METHODIST HOSP HENDERSO

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RA PRE MORTAL	D RATES
ALL CAUSES	1,578	10 %	8	TO 15 %
CA - CANCER	66	29 %	15	TO 39 %
CE - CEREBROVASCULAR ACCIDENTS	56	30 %	19	TO 44 %
EY - OPHTHALMOLOGIC DISEASE	5	0 %	0	TO 100 %
GC - GASTROINTESTINAL CATASTROPHES	23	26 %	7	TO 41 %
GI - GASTROINTESTINAL DISEASE	179	4 %	2	TO 10 %
GU - UROLOGIC DISEASE	81	1 %	1	TO 14 %
GY - GYNECOLOGIC DISEASE	12	0 %	0	TO 100 %
HL - LOW-RISK HEART DISEASE	151	5 %	2	TO 9 %
HM - SEVERE CHRONIC HEART DISEASE	93	17 %	14	TO 32 %
HS - SEVERE ACUTE HEART DISEASE	58	40 %	23	TO 49 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	29	10 %	6	TO 37 %
OP - ORTHOPEDIC DISORDERS	101	2 %	0	TO 8 %
PN - PULMONARY DISEASE	191	12 %	13	TO 26 %
RN - RENAL DISEASE	14	14 %	3	TO 49 %
SE - SEPSIS	14	29 %	15	TO 64 %
TR - SEVERE TRAUMA	47	11 %	2	TO 20 %

Flaget
Memorial
Hospital

October 26, 1987

Dr. William Roper, Administrator
Health Care Financing Administration
Washington, D.C. 20201

The purpose of this letter is to provide appropriate comments on the hospital specific mortality data being published by HCFA. Also attached as Appendix A, are corrections of reporting errors made both by HCFA and the Hospital.

The hospital has one diagnostic category, cerebral vascular accident [CE], in which the actual mortality rate is outside the range of the predicted mortality rate. Our actual mortality rate according to HCFA for this category is 58%. The range of predicted mortality rate for this category is 11 - 50%. A review of these cases by hospital personnel and the medical staff, generated the following information:

Of the eleven CE cases, two patients died after discharge from the hospital. Both deaths were anticipated at the time of discharge. One was admitted to a nursing home and subsequently died. The other patient was discharged to home and died. Ages were 84 and 95 respectively.
Of the eight cases in this category who died in the hospital, all but one had comorbidities. The one case which did not have a comorbidity, had a hospital stay of 5 hours and was made a DNR after admission. She was admitted in an unconscious state. The average age admitted in diagnostic category [CE] was 83, which is a significant factor related to mortality.

The diagnostic category in which the majority of deaths occurred after discharge was pulmonary disease, [PM]. After verification of HCFA data, the hospital confirmed 6 patients died after discharge in this category out of a total of 9 patients. It was determined by physician review that except for one, all were anticipated deaths at discharge. This one patient had several chronic comorbidities.

From the total of 76 patients who died, 26 of those were admitted from a nursing home to the hospital. Of the 76 deaths, 20 occurred out of the hospital. Of those 20, 12 patients went to a nursing home and subsequently died. Seven patients of the 20 died at home, one patient died at another acute care facility after transfer.

201 Cathedral Manor
Bardstown, KY 40004-1299

502-348-3923

A Division of
the Sisters of Charity
of Nazareth Health
Corporation

For the record, we would like to affirm that our facility, through its Medical Staff currently evaluates all deaths which occur in the hospital to ensure that appropriate care was given. We would also like to note that death review is an outcome indicator which is not ordinarily a direct measure of quality for hospital performance. We recognize that it can identify possible problem areas for peer review and we use it as such. HCFA's model, by its own admission is flawed. It measures a relationship between mortality and a particular group of characteristics associated with illness. Essentially the model used establishes a baseline or average probability of death, after controlling for selected characteristics. However, this is assuming that all patients are average, just as HCFA has done with DRGs. The predicted mortality rates are simply average mortality rates that could be experienced by a hospital treating similar patients to those admitted to our hospital.

We understand and appreciate HCFA's purpose in publishing the mortality data. We believe the public should be informed as to the quality of care that providers are dispensing. We do not support dissemination of selected data, which when taken out of context, may distort the actual quality of care given at any institution. We applaud HCFA's efforts in providing a more rational approach to the dissemination of mortality data than last year. However, we think it is imperative that the public reading this information be made aware of weaknesses in the methodology which may limit the reliability and validity of this information. Further the public should be made aware that HCFA has not included severity of illness, an important factor which must be considered during examination of mortality. We would also like to reiterate that HCFA data does not actually, directly measure hospital performance. Our hospital, like most hospitals in the United States has in place a quality assurance program which assesses the care given its patients using a wide variety of criteria, among which is an analysis of deaths in the hospital. This program's process is a much better analytical and educational tool than simple mortality rates alone.

Sincerely,

Michael K. McAndrew

Michael K. McAndrew
President/CEO

:vb

APPENDIX A

There were some discrepancies between HCFA's information and the hospital's statistics. Specifically:

[redacted] - The death as reported by HCFA occurred on 4/27/86. According to health department records, actual death occurred on 4/28/86.

[redacted] - According to HCFA published data, the discharge date was 12/7/86. That date should be changed because it was incorrectly reported by the hospital. The actual date of discharge was 12/8/86. Therefore, the patient was an in-hospital patient at death.

[redacted] - This patient was reported admitted 12/15/86, discharged 12/27/86 and died 1/7/87. However, the HCFA data did not include an admission date of 1/6/87, which was the last admission of this patient, and the patient died on 1/7/87 in the hospital.

GOOD SAMARITAN HOSPITAL
310 SOUTH LIMESTONE STREET • LEXINGTON, KENTUCKY 40508
TELEPHONE (606) 252-0612

J. J. PURVIS
PRESIDENT & CEO

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Hospital I.D. Number 180007

Gentlemen:

Thank you for this opportunity to respond to the release of data on hospital mortality for calendar year 1986. The Good Samaritan Hospital welcomes this information and will look forward to it being done annually, so that greater numbers of cases can be accumulated in each Diagnostic Category, thus improving the validity of the data.

Since receiving the report on September 23, Good Samaritan Hospital Staff, in conjunction with the Quality Review Department and the Medial Record Department has had an opportunity to review the data.

The Director of Medical Records has validated, that with minor exceptions, the data is accurate. The Vice President responsible for Quality Review has reviewed all cases reflected in this report.

All mortality occurring in the Good Samaritan Hospital is reviewed by the Quality Review Department along with the appropriate clinical service. The medical Staff of Good Samaritan Hospital is proud of our very comprehensive Quality Review program, which not only monitors and tracks mortality, but assesses each medical record as to appropriateness and quality of care received by the patients we serve. This is a concurrent and ongoing process dictated by our commitment to render to our patients the highest quality of care possible.

We are pleased to note that our mortality rate in all categories fall well within the predicted range. In fact, in 14 of the 16 Diagnostic Categories, we are in the lower half of the range. Considering the Good Samaritan Hospital receives many patients by transfer from, and acts as a tertiary hospital for 40 counties in Central and Eastern Kentucky, we find these numbers to be gratifying. Many of these patients are complicated, and quite severly ill when we receive them.

The Medical Staff of the Good Samaritan Hospital, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Thank you for giving us an opportunity to comment on the data.

Sincerely,

Richard H. Mortara, M.D.
President, Medical Staff

J.J. Purvis
President/CEO

RHM/JJP/smm

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

This letter is written to comment on the 1986 mortality statistics for Harrison Memorial Hospital. Comments were solicited by HCFA when this data was sent to hospitals on September 21, 1987.

My first comment involves the accuracy of the information provided by HCFA. Our investigation of this information indicates it is correct with regard to Date of Admission, Date of Discharge, Date of Death, and Principal Diagnosis. The Age listed for the patients varies on a few occasions. However, the most significant discrepancy is in regard to the number of deaths reported. The patient-specific listing included with the mortality rates indicates 90 deaths occurred at our facility. Our records indicate we had 97 deaths, if we add the 18 out-of-facility deaths.

I have several general comments regarding the format of this information and its usefulness. My first comment with respect to format is that the methods used to generate the number of cases and mortality rate are flawed. The number of cases should represent the total number of admissions to the Hospital, not the number of patients whose last admission was in 1986. If the figures are being released to inform the public of the likelihood of death occurring while at a particular hospital, the number of "successful" discharges should also be included in the mortality rates.

My second comment involves the method of calculating the Actual Mortality Rate. The method used includes the deaths which occur within 30 days of the admission date -- not after discharge. These deaths may be due to automobile accidents, homicides, suicides, etc. Again, I doubt that hospital mortality statistics are of much use if these causes of death are included.

JAMES R. FARRIS, ADMINISTRATOR
POST OFFICE BOX 250 • CYNTHIANA, KENTUCKY 41031-0250 • (606) 234-2300

KY 41

Another comment I have regarding the release of the mortality statistics is the fact that the average healthcare consumer will not have sufficient information to use the data for its intended purpose. Without an indication of the severity of illness treated by a facility, one cannot determine if the mortality rate is unacceptably high or not. Information on the types of patients treated and the severity of illness or injury must be presented along with the data.

The public as a whole is not sophisticated enough to properly analyze the information HCFA plans to release in December. Though I am certain several disclaimers will be included with the release of this data, the public will judge hospitals solely on the basis of an uninformed look at the statistics.

In conclusion, I would ask that future releases of information involving mortality or morbidity be done in a manner that will ensure an adequate understanding on the part of the public. The method used in the distribution of the 1986 mortality statistics will only serve to misinform the public.

Sincerely,

James R. Farris
Administrator

JRF:cjm

Bourbon General Hospital

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to comment on the upcoming release of selected mortality information. Attached please find comments that I believe are appropriate to include with the selective data relative to our facility.

Please contact me if I can provide additional assistance or information.

Sincerely,

Gerald A. Fornoff
Administrator
GAF/cg

#9 Linville Drive
Paris Kentucky 40361
Telephone (606) 987-3600

COMMENTS ON THE HFCA MORTALITY DATA
HCA BOURBON GENERAL HOSPITAL
PARIS, KENTUCKY

Data Verification:

Bourbon General Hospital falls well within the range of predicted mortality rates on all 15 diagnostic categories. The data used by HFCA indicate that a total of 51 Medicare patients admitted to Bourbon General Hospital died within 30 days of admission. According to the HFCA data, 37 died while still a patient of the hospital while 14 died after discharge. Our own records indicate that 731 total Medicare admissions occurred in 1986 as opposed to the 430 denoted in the statistic. Presumably the discrepancy reflects both multiple admissions of individual beneficiaries to Bourbon General as well as to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Bourbon General Hospital is correct. Our own records indicate that of the 51 Medicare patients who died within 30 days of admission, 14 were still alive at the time of discharge (27%).

Without detailed information concerning billing data available to HFCA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks:

Although as noted above the hospital's actual mortality rate falls within the range of predicted mortality rates, there are two diagnostic categories that merit comment; 1) HS-Severe Acute Heart Disease. Of the total 8 expired patients, two were alive at discharge from our facility. Further, the average age was 77 with most of the patients on ventilator support. 2) SE-Sepsis. Only two patients were in this category, equating to 33 1/3% of the total 6 cases; this is opposed to the HFCA Mortality Rate of 50%. Concerning these two cases, one was a 89 year old patient with bilateral pneumonia as well as sepsis, and the other was chronic alcoholism patient with chronic pancreatitis.

In reviewing the HFCA data, the following points are of most significance:

1) Bourbon General was well within the acceptable range of predicted mortality rates in all categories.

2) Of the 51 deaths stated to have occurred within 30 days of admission, 27% of them occurred after discharge from our facility.

Highlands
Regional
Medical
Center

[illegible] • [illegible] • [illegible]

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Medicare Provider Number 18-0005

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates at Highlands Regional Medical Center for 1986.

Highlands Regional Medical Center is a 184 bed acute care facility and is pleased to be recognized by your agency as the only Rural Referral Center in the Eastern Kentucky area. As you know, having this distinction means that the Medical Center has demonstrated that it takes care of patients whose severity of illness is greater than would be expected of most rural hospitals. Considering this, Highlands Regional Medical Center is proud to see that its outcome of quality care delivery in all categories rated us below your range of predicted mortality rates. Also our overall mortality rate of Medicare patients is very near the bottom range of predictable mortality rates for the nation.

A medical staff committee monitors every death that occurs in our facility as well as many other quality aspects of patient care. We believe that our monitoring systems provide us with a reliable continuous feedback which allows us to maintain and improve the quality of care we render to all our valued patients. We think this statistical presentation by your office, which we regard as a valuable educational tool, demonstrates our success.

Clarence C. Traum
Administrator

Jerry D. Fraim, M.D.

Jerry D. Fraim, M.D., Chairman
Quality Assurance Committee

One Audubon Plaza
PO Box 1758
Louisville, KY
40217
Telephone 502 636 7111

Humana Hospital Audubon

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Dear Dr. Roper:

Humana Hospital-Audubon supports the Health Care Financing Administration's desire to educate the public about Medicare quality issues. Audubon appreciates the goals of HCFA's recent release of mortality data, though it represents preliminary and, in some cases, rough data. We find this information helpful and complimentary to the hospital's ongoing review of all admissions which is continuously conducted by quality assurance and utilization review committees. We are also subject to periodic review by outside agencies including the Joint Commission on Accreditation of Health Organizations.

As in all deaths occurring at Humana Hospital-Audubon, a complete internal review is necessary to determine the appropriateness of the outcome. This review may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, these statistics may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

It is, however, difficult for the general public to utilize such mortality data when there is consideration for only a limited number of patients and little or no adjustment of the figures based on severity of illness. Consequently, the raw numbers reflecting deaths which occurred in only a limited segment of hospitals' patient population, should be only one of numerous indicators to review an individual facility. Therefore, it seems essential that consumers be informed as to the limited scope of these numbers and be cautioned about drawing broad conclusions concerning a particular hospital's services.

In reviewing the data presented about Humana Hospital Audubon, our Executive Staff and Quality Assurance Committee are satisfied that these statistics place us within the norms of every category. Unfortunately, in most cases the number of patients in a particular category do not always provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable standards.

I trust this response will be helpful in refining and reporting the raw hospital data. Humana Hospital-Audubon will assist our community in understanding the HCFA data and understanding how the data can best be utilized to improve health care services.

Please don't hesitate to contact me if you have any questions or comments. Thank you.

Yours sincerely,

Bruce MacLeod

Bruce W. MacLeod
Executive Director

BWM:rap

Humana Hospital
Lexington

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided us late last month. Humana Hospital - Lexington supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of the hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's Medical Records and Quality Assurance Departments have reviewed the data. Since ten (10) of the deaths occurred outside the hospital, we have been unable to completely validate this date. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Bradley K. Grover, Sr.

Bradley K. Grover
Executive Director

BKG:dab

P.O. Box 769
Highway 644
Louisa, Kentucky
41230
Telephone 606 638-9451

Humana Hospital
Louisa

October 20, 1987

Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Gentlemen:

Thank you for the opportunity to comment on the hospital's specific mortality data provided to us last month. Humana Hospital - Louisa supports the Healthcare Financing Administration's desire to educate those interested in medicare quality issues. We recognize that this program is early in its development stages. While its measurements are preliminary and rough, it is cleary an example of the type of quality measurements to come.

This information will be helpful in our hospital's on-going quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well a complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occur in only a limited segment of the hospital's patient population namely the elderly, and are not adjusted for severity of illness or other factors which may effect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers and be cautioned about drawing upon conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements that can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally,

they may assist healtcare consumers in understanding the extensive quality control systems in place in hospitals. Our hospital's Medical Records Department has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable (standards).

While all the categories listed for Humana Louisa fall below the predicted mortality rates, it must be pointed out that of the 93 cases listed for this hospital the average age is 78.9 years old. There are only two patients below the age of 60 years of age. In addition, the hospital is the sole provider within the service area and has a 140 bed nursing home within two blocks from which a large portion of our admissions originate.

I hope this information will be helpful in attempting to refine the collection and reporting of all hospital data. In addition, our hospital will do everything possible in assisting our community in understanding how this data can best be used to improve healthcare services.

Sincerely,

James J. Ellison
Executive Director

/pjw

9820 Third Street Road
Louisville Kentucky
40272
Telephone 502 933-2110

Humana Hospital Southwest

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Sir:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-Southwest supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which

can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records department has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent, with some exceptions, with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can be used to improve health care services.

Sincerely,

John A. Fromhold

John A. Fromhold
Executive Director

JAF:dwa

4001 Dutchmans Lane
Louisville, Kentucky
40207
Telephone 502 893-1100

Jeffrey S. Holland
Executive Director

Humana Hospital Suburban

October 28, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific Mortality Data provided to us late last month. Humana Hospital - Suburban supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing Quality Assurance program that includes regular and complete review of all admissions which result in patient mortality, regular Morbidity and Mortality reviews, Quality Assurance, Utilization Review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations, including State Medicare Reviews.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Some deaths occurred outside the hospital, and we have, therefore, been unable to completely validate this data. In some cases, the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Jeffrey S. Holland
Executive Director

530 South Jackson Street
Louisville, Kentucky
40202
Telephone 502 562-3000

Humana Hospital University

October 26, 1987

William L. Roper, M.D.
Health Care Finance Administration
Health Care Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - University supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may

provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records staff has reviewed the data. Since 27% of the deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent, with some minor exceptions, with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

Humana Hospital - University is a tertiary care and referral center. We have reviewed all categories and are satisfied with the appropriatness of care provided these patients. In our review, patients in the sepsis category were found to have serious cronic medical problems and 25% of these patients were admitted through the Emergency Room. This is an indication of these patients severity of illness.

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

David G. Laird
Executive Director

DGL:vb

305 Langdon Street
Somerset, Kentucky
42501
Telephone (606) 679-7441

Humana Hospital
Lake Cumberland

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I would like to thank you for the opportunity to comment on the hospital specific mortality data that you provided us last month. Humana Hospital-Lake Cumberland supports HCFA's efforts to educate those interested in Medicare quality of care issues.

We intend to use the hospital mortality data that you have provided in our hospital quality assurance program which includes a complete review of all patients. We believe that this data may be helpful when reviewed by quality assurance and utilization review committees, as well as appropriate outside reviewing bodies such as the Joint Commission on Accreditation of Health Organizations.

Your raw numbers reflect deaths which occur in a limited segment of our hospital's population, specifically the elderly, and are not adjusted to reflect severity of illness or any other factors which may affect patient outcome. Therfore, they must be interpreted in that context and should serve as only one of many indicators that should be used to review the quality of services provided by an individual hospital. I firmly believe that this statistical data, while somewhat useful for professional evaluations, is of absolutely no value to consumers. Therefore, consumers should be informed of the limitation of these numbers and strongly cautioned not to draw conclusions from the data in relation to any particular hospital.

We have reviewed the data to a limited degree. Since approximately 20% of the deaths reported for our particular hospital occurred outside of the hospital, it is impossible for us to completely validate the information. For those deaths which occurred on patients in our hospital, we have found the data to be consistent. However, several of the categories contain such a small number of patients that it is impossible to have a valid statistical base to analyze. Also, some of the predicted ranges are so broad and have been developed in such an unverifiable manner it is impossible and inappropriate to consider them either acceptable or unacceptable standards.

I appreciate the opportunity to comment on the data prior to its release.

Sincerely,

Derek W. Cimala
Executive Director

DWC/bmd

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Jennie Stuart Medical Center, in response to the Health Care Financing Administration s plan to publish mortality rates for Medicare patients. has developed the attached comments.

We hope that our comments will be reviewed carefully and included in the final publication as indicated in your letter of September 21. 1987. There were discrepancies in the HCFA data and our data. Hopefully this will be taken into consideration, helping to prevent publication of inaccurate information about our hospital.

If any additional information is needed, please do not hesitate to contact me.

Sincerely,

James H. Walker. Administrator

Jennie Stuart Medical Center

JAMES H. WALKER,
Administrator

320 West 18th Street
Hopkinsville. Kentucky 42240
(502) 886-5221

COMMENTS ON THE HCFA MORTALITY DATA
Jennie Stuart Medical Center, Hopkinsville, Kentucky

Data Verification

The data used by HCFA indicate that a total of 248 Medicare patients admitted to Jennie Stuart Medical Center within the study period died within 30 days of admission. Of these, 204 died while still a patient in the hospital, while 44 died after discharge. Without detailed information concerning billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the the reported analysis. HCFA data reflects patient s diagnosis from their last hospitalization.

Our own records indicate that 2420 Medicare admissions occurred during the study period (1986). It is significant that 6923 total hospital admissions occurred during this same period (1986) at Jennie Stuart Medical Center with a total number of deaths recorded at 271 (67 were Non-Medicare patients, 204 were Medicare patients included in HCFA s data) for an overall mortality rate of less than 4%. In addition, USDHHS (United States Department of Health and Human Services), State Life Tables, indicate that life expectancy is 77.12 for females and 69.14 for males. Breakdown of the 44 deaths after discharge reflected the average age for the 20 females was 82 and the average age for the 24 males was 75.

Verification of the HCFA data by hospital personnel and members of the Hospital Medical Staff indicated that JSMC s Medicare adjusted mortality rate was 11.5%. This average is within the acceptable range of hospital mortality rates for Medicare patients.

Interpretive Remarks

In one of the diagnostic categories, Severe Acute Heart Disease, the hospital s reported mortality rate falls outside of the range of the predicted mortality rate. After correcting the errors in the recording of deaths, the mortality rate for JSMC falls within the normal acceptable range established by HCFA. Several factors may account for this and are discussed below under the results of preliminary Medicare record review. In three additional diagnostic categories the HCFA reported mortality rate approach but does not exceed the range for predicted mortality. These are in Severe Chronic Heart Disease, Gastrointestinal Disease and Gastrointestinal Catastrophe. These categories are likewise discussed in the following results section of a preliminary Medicare record review undertaken by this institution.

SEVERE ACUTE HEART DISEASE

HCFA data indicated that of 59 Medicare patients hospitalized at Jennie Stuart Medical Center with severe acute heart disease during the study period (1986), 31 died for a mortality rate of 53%. Of the cases under consideration, one died outside the hospital and confirmation of this death is not available. Five of these cases died due to pulmonary disorders rather than cardiac causes. Fourteen of the cases studied were greater than 80 years of age. Eleven of the remaining cases were over 70 years of age. It is significant that most of these patients had other pre-existing severe illness. Patients who are younger or are not at prohibitive risk of dying in transport are usually transferred to other institutions for balloon angioplasty, coronary

bypass procedures or treatment. Therefore, only those patients deemed too ill for transport would be included in the Jennie Stuart Medical Center study group entitled Severe Acute Heart Disease. This would explain a higher mortality rate than the national average. However, as noted above, our preliminary study indicates an adjusted mortality rate of 42% (53). This is well within the HCFA range of predicted mortality rates. Discrepancy between our study and the HCFA figures appears to come from a lack of detailed information available to HCFA reviewers on the specific cases cited.

SEVERE CHRONIC HEART DISEASE

HCFA data indicate that 26 of 86 Medicare patients hospitalized at Jennie Stuart Medical Center within the past year died with a principal diagnosis of chronic heart disease for a mortality rate of 31%. A study of these cases at our institution indicated that 8 of these cases did not die as a result of heart disease. The 8 cases that did not die from severe chronic heart disease died from Digitalis toxicity, eletrolyte imbalance, severe anemia due to renal failure, TB, pulmonary insufficiency, COPD. It is significant that 16 of the patients studied in this category were above 80 years of age and only two patients were less than 70 years of age. The adjusted mortality rate based on our preliminary data was 21% (18 of 78 cases).

GASTROINTESTINAL DISEASE

HCFA data indicated that of 244 Medicare patients hospitalized at Jennie Stuart Medical Center during the study period (1986) with gastrointestinal disease, 18 died for a mortality rate of 8%. The presence of oncology services and a comprehensive gastroenterology service undoubtedly contributed to the complexity of cases hospitalized here. All but two of the deaths in the study occurred in the hospital. Of the two who died outside the hospital both were in the process of dying from cancer.

Of the total 17 patients studied, the cause of death was a result of liver failure, pneumonia, congestive heart failure, sepsis, ruptured aortic aneursym and cardiac arrest. It is impressive to note that 12 of the 17 cases were 80 years of age or older and the remainder were 70 years of age or older.

GASTROINTESTINAL CATASTROPHE

HCFA data indicated that 10 of 34 Medicare patients with gastrointestinal catastrophe died at this facility during 1986 for a mortality rate of 35%. Of the ten cases cited under Gastrointestinal Catastrophe, 7 were admitted for terminal care from a nursing home or other institution. Five of these 7 were admitted with terminal cancer. One additional patient died from a myocardial infarction while in the hospital. It should be noted that 6 of the patients were over 75 years of age and 4 of these over the age of 80. The actual number of cases who died as a result of gastrointestinal catastrophe was 4. The adjusted mortality rate for Medicare patients due to gastrointestinal catastrophe on our review was therefore 12%.

The discrepancy in mortality figures between the Jennie Stuart Medical Center study and the HCFA statistics appears to come from a lack of detailed information available to HCFA on the specific cases cited.

CORRECTED DATA

Severe Acute Heart Disease

HCFA	JSMC
59 cases	59 cases
31 deaths	31 deaths
53% mortality rate	25 cases-death was due to severe acute heart disease.
	6 cases were not related to severe acute heart disease.
	42% Mortality rate

Severe Chronic Heart Disease

HCFA	JSMC
86 cases	86 cases
26 deaths	26 deaths
31% mortality rate	18 cases-death was due to severe chronic heart disease
	8 cases were not related to severe heart disease.
	21% mortality rate

Gastrointestinal Disease

HCFA	JSMC
244 cases	244 cases
18 deaths	18 deaths
8% mortality rate	5 cases-death was due to
	13 cases were not related to gastrointestinal disease.
	3% Mortality rate

Gastrointestinal Catastrophe

HCFA	JSMC
34 cases	34 cases
10 deaths	10 deaths
35% mortality rate	4 cases-death was due to GI catastrophe
	6 cases were not related to GI catastrophe.

Jewish Hospital

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

RE: Jewish Hospital, Louisville, Kentucky
Medicare Provider Number 18-0040

Dear Dr. Roper:

This letter is written in response to the Health Care Financing Administration's (HCFA) request for comments on the publication of 1986 hospital mortality information for Medicare patients.

Jewish Hospital is a 454 bed, acute care, tertiary medical center committed to providing the highest quality medical services available. Dedication to a high risk medical agenda coupled with research and teaching programs with the University of Louisville School of Medicine continues to enhance Jewish Hospital's recognition as a regional referral center.

While the calculated mortality rates for Jewish Hospital are well within the ranges predicted by HCFA, a detailed analysis has been conducted by the Hospital and Medical Staff. It is important to note that analysis of the information provided revealed no unexpected results or inconsistencies as compared with mortality review performed by the Hospital Medical Staff and Quality Assurance Department on an ongoing basis.

The data reflects the highly acute medical conditions of patients seeking care at Jewish Hospital. For example, one fourth of all Medicare patients who died were transferred in from other hospitals or nursing homes who could not provide appropriate levels of care. Further, 98% of all Medicare deaths occurring in the Hospital were either patients with chronic terminal disease or were patients at significant risk (i.e., patients with multiple heart attacks) at the time of admission.

Validation of the numbers of Medicare beneficiaries whose last admission was to Jewish Hospital in 1986 was not possible since detailed information was not provided to hospitals. However, based on available data, Jewish Hospital serves as the leading

217 East Chestnut Street
Louisville, Kentucky 40202-1886
(502) 587-4011

provider of care for Medicare patients in the Louisville area. In 1986, over 6,300 Medicare patients were admitted -- a greater number than any other Louisville hospital. In addition, Jewish Hospital served one of the most acutely ill groups of Medicare patients in the Commonwealth, according to a Case Mix Index developed by the Federal government.

As a major, regional medical facility, Jewish Hospital strongly supports the public's right to make informed decisions regarding their healthcare. We share your stated belief that while information on hospital Medicare patient mortality rates is useful, it cannot be used by itself to make comparisons or judgments regarding hospitals. Because mortality rates for Medicare patients are only a single, limited indicator, we concur with your efforts to continue development of reliable indicators to provide consumers useful information for making choices regarding their healthcare.

Finally, we believe patients should be encouraged to consult their physician with questions they may have regarding the published data, insofar as they are the best source of information regarding quality of care.

Sincerely,

Douglas E. Shaw
Senior Vice President
Chief Operating Officer

James L. Bersot, Jr., M.D.
President
Jewish Hospital
Medical Staff

DES/JMB/ddf

King's Daughters' Medical Center

2201 Lexington Avenue • Ashland, Kentucky 41101 • (606) 329-2133

October 26, 1987

Health Care Financing Administration
William L. Roper, M.D.
Administrator
Health Standards and Quality Bureau
Hospital Mortality Information
P . O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Enclosed please find an evaluation of the mortality review for 1986 Medicare deaths, as requested on September 21, 1987. Following the review significant discrepancies were noted. According to our information, fifty eight (58) patients could not be found on our death listing as patients who expired at King's Daughters' Medical Center.

The discrepancies were reported to Mr. Harvey Brook on October 16, 1987 by Wilda Beardsley, RN, DRG coordinator. He suggested a summary report be submitted (see attachment). The report will also be forwarded to Nancy Galvagni at the Kentucky Hospital Association.

Please review this information and determine the changes that are indicated to validate an accurate mortality rate.

Should additional information be required, please do not hesitate to contact me.

Sincerely,

C. Timothy Maloney
President/CEO

CTM/jdc

Enclosure
cc: Nancy Galvagni

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Knox County Hospital Operating Corp.
ADMINISTRATIVE OFFICES 321 HIGH STREET
P.O. BOX 260
BARBOURVILLE, KENTUCKY 40906

TELEPHONE (606) 546-4175

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

I am addressing your latest mortality information in regard to our facility, in the following paragraphs, as it applied to us.

There were, according to our records, 964 Medicare admissions to this hospital during the year 1986. According to your report there were only 445 admissions. You have not taken into consideration the number of indigent elderly people who do not quality for part A Medicare benifits. 15-20% of our patients over 65 are covered by Medicaid, not part A Medicare. I feel you have also failed to recognize the fact that this part of the country has an extremly large number of people who are not covered by medicare. There is also no mention of other third party liability coverages for the elderly patients who are covered by retired teacher's funds (Aetna) automobile and homeowner's insurance's, etc.

There were 40 actual Medicare deaths in this hospital for the year 1986. Your records indicate there were 57. 17 of these deaths occured after discharge. 2 of these patients that you have indicated on your list were transferred to another acute care hospitals and died there. 15 of the deaths you have attributed to this hosptial were discharged to skilled nursing facilities or discharged home. A review of these patient records revealed that three (3) died in the nrusing home of completely unrelated diagnosis to that of the hosptial admission. Two (2) died at home with the same circumstance.

An intense review of all deaths in this hospital for the year, showed that 28 of those patients who died were admitted in comatose states due to terminal diseases, death was anticipated, even on admission.

The diagnosis used by Medicare to tabulate their data is based on the admission or principal diagnosis and this many times is not the cause of death. Coding guidelines prohibit the use of terminal diagnosis as the principal, unless the patient actually dies on that hospital admission. If he is discharged, he then falls into a low risk catagory, even though death was due to a long term chronic or terminal disease state.

Cont.

October 26, 1987

Health Care Financing Administration
Hospital Mortality Information

Cont.

Page 2

Due to a shortage of skilled beds in this rural area and a profound indifference of the general population in placing their family members in a nursing home, the hsopital finds itself responsible for providing terminal care. This information then, should not be used to degrade a hospital, for supplying these services.

Our records indicate that 3,139 admissions were registered during 1986 with 60 total deaths during that period, including stillborns. This death rate is calculated at 1.8%. The total Medicare admissions were 964 with a calculated death rate of 5.7%.

Average age of those patients who died in this hospital was 80.25 years. What is the average life expectancy?

[redacted] died in Good Samaritan Hospital in Lexington.

[redacted] died at St. Joseph's Hosptial in Lexington.

[redacted] died in Nursing Home of aspirational pneumonia - treated in hospital for anemia.

[redacted] died in Nursing Home of aspirational pneumonia. Treated in the Hospital for Acute Coronary Insufficiency.

[redacted] died in Nursing Home of Septicema due to Stage 4 decubitus ulcers - treated here for U.T.I. , Cultures were negative in Hospital.

[redacted] treated here for dehydration died at home of acute M I.

I sincerely hope you will consider this information and respond accordingly.

Sincerely,

Ray B. Canady
Administrator

RBC/lh

Attachment I/page

MORTALITY REVIEW SUMMARY

DIAGNOSTIC CATEGORIES	"Cases" Reported by HCFA	"Cases" Verified by Hospital	Deaths Reported by HCFA	Deaths Verified by Hospital	In-hospital Deaths	Post-discharge Deaths	Cases Requiring Further Review
HIGH RISK							
Cancer	7	10			9	1	
Stroke	17	9			6	3	
Severe acute heart	15	10			8	4	
Severe chronic heart	14	9			10	0	
GI catastrophies	7				0	1	
Metabolic/electrolyte	27				0	2	
Pulmonary	48				9	1	
Renal	3				1		
Sepsis	1				0	2	
Severe Trauma							
LOW RISK							
Ophthalmologic							
Gynecologic							
Low risk heart							
Gastrointestinal					0	1	
Urologic							
Orthopedic conditions	12				1	0	

Livingston County Hospital, Inc.

P.O. Box 138
Salem, Kentucky 42078
(502) 988-2299

October 12, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Data Verification

The data used by HCFA indicates that a total of 17 Medicare patients admitted to Livingston County Hospital died within 30 days of admission. Of these, 15 died while still a patient of the hospital, while 2 died after discharge. Our own records indicate that 554 Medicare discharges were recorded for 1986. Also 1 patient was included in these statistics who actually died in 1987.

Overall, the database contains mortality rates that are within the "Range of Prediction"; however, this is not a true reflection based on your method of computing statistical information.

When considering the following facts:

1) Small Rural Hospital with 26 beds
2) Population age greater than 55-60
3) More than half of all admissions medicare
4) Underlying pre-established chronic conditions

With the above additional facts our mortality rate is actually lower than the printed statistical data base.

It is important to keep in mind when reviewing the data released by HCFA that the mean age of our patients who died was 75 years old and they all had chronic, life threatening, underlying conditions. These figures do not reflect the quality of care or measure the hospital's performance. The difference may, in fact, result from factors not included in the predictive model.

Sincerely,

Ben Hesen

Ben Hesen
Chief Executive Officer

BH/pp

Marcum & Wallace Memorial Hospital
201 Richmond Avenue
Irvine, Kentucky 40336
(606) 723-2115

October 27, 1987

William Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I very much appreciate the ability to comment on the Health Care Financing Administration hospital mortality statistics.

The Health Care Financing Administration (HCFA) has intended this data to be used in hospital quality assurance programs identifying areas for review. Quality of care is of the utmost concern to Marcum and Wallace Memorial Hospital's governing board, management and medical staff. Any indication of potential quality problems, including a mortality rate that is higher or lower than predicted, leads to a prompt investigation to determine if a problem, in fact, exists. In terms of Marcum and Wallace Memorial Hospital's mortality rate, all deaths are reviewed by members of the medical staff on an ongoing basis. When quality problems are identified, corrective action is immediately taken through the proper quality assurance channels.

The statistical model developed by HCFA measures the relationship between a limited number of patient characteristics and the risk of death. However, in order for it to be useful it is important that data of this nature be reliable and valid. In determining the usefulness of the mortality rates provided by HCFA it is imperative to consider a number of issues.

HCFA's data assumes that each hospital's patients are "average" except with respect to the few characteristics included in the statistical model. The model does not include measures of severity (i.e. how ill the patient was at time of admission), whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, the patient's psychological state or general health status. Marcum and Wallace Memorial Hospital treats a large geriatric population with multi-system disease. This automatically puts the patients into a high risk category upon admission. Therefore, the kind of Medicare patients that are admitted to Marcum and Wallace Memorial Hospital are not necessarily the "average" Medicare patient HCFA used in determing the range of predicted mortality rates.

Another consideration is the model has not been validated. It has not been determined whether the hospital whose actual mortality rates are outside the predicted range are more or less likely to provide higher or lower quality of care. This model does not measure the hospital's performance on quality but measures the relationship between mortality and a selected group of patient characteristics.

Finally, it should be noted that the HCFA data is not all-inclusive. The mortality rates apply only to Medicare patients and differ from other indicators of inpatient mortality. These rates are calculated using only deaths that occurred within 30 days of the last admission of a Medicare beneficiary to a hospital during 1986. These mortality rates also reflect deaths that occurred outside of the hospital within 30 days of the admission date.

In order to show the impact that these differences have on mortality rates the following is Marcum and Wallace Memorial Hospital's actual Medicare mortality rate using the traditional approved method of calculation:

$$\frac{\text{Total Medicare Deaths}}{\text{Total Medicare Admissions}}$$

This rate is 7.49% for Marcum and Wallace Memorial Hospital.

Marcum and Wallace Memorial Hospital has and will continue to take any and all action to ensure quality that has been identified by the HCFA mortality data. We are aware that the Americal Hospital Association and the Joint Commission on the Accreditation of Health Organizations as well as other organizations are investigating methods of evaluating hospital quality that rely on measures other than mortality rates. We are looking forward to the results of these efforts.

Sincerely,

Daniel F. Sheehan

Daniel Sheehan,
Administrator
Marcum and Wallace Memorial Hospital
Provider # 180058

DS/rr

HOSPITAL = 180058 MARCUM WALLACE MEMORIAL HOSP IRVINE KY

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	250	15 %	8 TO 18 %
CA - CANCER	7	71 %	9 TO 70 %
CE - CEREBROVASCULAR ACCIDENTS	8	38 %	8 TO 65 %
EY - OPHTHALMOLOGIC DISEASE	1	0 %	0 TO 100 %
GC - GASTROINTESTINAL CATASTROPHES	4	0 %	1 TO 75 %
GI - GASTROINTESTINAL DISEASE	11	0 %	0 TO 44 %
GU - UROLOGIC DISEASE	7	0 %	1 TO 57 %
HL - LOW-RISK HEART DISEASE	29	3 %	1 TO 22 %
HM - SEVERE CHRONIC HEART DISEASE	19	42 %	10 TO 48 %
HS - SEVERE ACUTE HEART DISEASE	5	40 %	12 TO 82 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	22	0 %	7 TO 43 %
OP - ORTHOPEDIC DISORDERS	7	0 %	0 TO 84 %
PN - PULMONARY DISEASE	40	28 %	8 TO 34 %
TR - SEVERE TRAUMA	1	0 %	0 TO 100 %

Meadowview Regional Hospital

989 West Highway 10
Maysville, Kentucky 41056

MEADOWVIEW REGIONAL HOSPITAL
PROVIDER NO.: 180019

UNDERSTANDING HCFA MORTALITY DATA

Interpreting HCFA's release of mortality data on Medicare patients can be quite complex. For a better understanding of the information, a few points should be kept in mind. First, the mortality data was derived from a statistical model based on the assumption that each hospital's patients are "average" except with respect to the few characteristics included in the model. In other words, the model does not include measures of severity. Second, the model has not been validated. Deviations from the predicted mortality rate do not necessarily mean there are problems with the quality of care provided in a particular hospital, but could easily reflect the exclusions of some significant factors influencing the risk of death. Finally, the HCFA data is not not all-inclusive. Only Medicare deaths that occurred within 30 (thirty) days of the last admission to a hospital during 1986 were considered in calculating the mortality rates.

The following are some specific factors related to our hospital that we feel will help you interpret the data more clearly.

(1) The diagnostic category is based on the principal diagnosis or the reason for admission to the hospital. Many times this an acute problem resulting from a chronic underlying disease. For example, one patient included in the "Metabolic/ Electrolyte Disturbances" category was admitted to the hospital due to dehydration. This patient had terminal metastatic cancer and later expired in a nursing home. Cancer was the underlying disease process causing death, however, the last admission was attributed to dehydration and therefore included in that category for reporting purposes. In conclusion, it is important to remember that the diagnostic category does not necessarily represent the cause of death.

(2) In many cases, death was the expected outcome at the time the patient was admitted. Seventy-two percent of our inpatient deaths included "no code" orders. In these cases, death was the result of following the patients wishes with respect to extra-ordinary efforts.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Meadowview Regional Hospital

989 West Highway 10
Maysville, Kentucky 41056

UNDERSTANDING HCFA MORTALITY DATA
MEADOWVIEW REGIONAL HOSPITAL
PROVIDER NO.: 180019

The HCFA mortality data is not, in itself, a measure of hospital performance. Under no circumstances should the data be used as a basis for judging the quality of care provided by a hospital. The data should appropriately be used an an aid to better focus on-going quality assurance activities within the hospital. At the present, organizations such as the AHA and Joint Commission are investigating methods of evaluating quality of care based on measures other than mortality rates and we look forward to their continued efforts.

METHODIST
EVANGELICAL
HOSPITAL

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
DEPARTMENT OF HEALTH & HUMAN SERVICES
Washington, D.C. 20201

Dear Dr. Roper:

First of all we would like to thank you for providing our hospital the opportunity to respond to the mortality statistics for the year, 1986. All of the data were reviewed by our Medical Records and Quality Care Management Departments under the supervision of the Medical Director, and were found with few exceptions to be an accurate account of the 1986 Medicare mortality statistics of Methodist Evangelical Hosptial.

Methodist Evangelical Hospital is a 372 bed non-profit, acute care general hospital with coronary and intensive care units containing 16 beds, a 32 bed telemetry, transitional care unit and an Oncology unit of 16 beds. Although the general medical and surgical services are the backbone of our institution, the hospital also features a Diabetic Unit, Joint Replacement Center and state-of-the-art obstetrical and Level II newborn services. In 1986, the Joint Commission on Accreditation of Health Care Facilities gave Methodist Evangelical Hospital the maximum 3 year certification of approval.

Naturally we are pleased and gratified that our overall mortality for Medicare patients was well within the predicated range, but even more so that we were within the acceptable range of mortality for each of the 16 diagnostic categories. However, there are certain factors which have been omitted from your review which we feel are essential for proper interpretation of the data.

1 - The actual number of Medicare admissions to our hospital in 1986 was 4452. Your mortality rates were based on 2730 admission which represent only the last admissions for those patients who died. Thus, there were many patients who eventually expired but who had multiple admissions during 1986. Assuming most of the patients were admitted for the same disease to which they finally succumbed, this would obviously lower the overall mortality rate considerably.

2 - Of the 277 patients who died in 1986, there were 58 who expired after discharge. Since we did not contact the families of the deseased as per your request, we had difficulity in establishing the cause of death for many of those patients who died after discharge from the hospital. Thus it is possible that a significant number of

315 East Broadway
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Louisville, Kentucky 40201-0843
(502) 585-2241

those deaths may have resulted from causes other than and perhaps unrelated to the diagnosis which occasioned their admission and upon which you based your findings.

3 - A significant number of the deaths were "NO CODES" meaning that the patient and/or family did not want any extraordinary measures undertaken to prolong life. Indeed, of the 30 patients who expired within 7 days of discharge, more than half were "NO CODES." This indicates that many of these 277 patients who died were in an incurable if not terminal state and that further therapeutic endeavors were inappropriate.

4 - The principal diagnosis upon which the deaths were categorized was not the cause of death in many instances. For example, the opthalmology case was admitted for cataract surgery, but died of unrelated kidney failure. This casts some doubt on the accuracy of the categorization.

5 - The average age of those who expired was 75 years. However, in several of the diagnostic categories, the average age was in excess of 80 years.

Death is but one of the possible outcomes of treatment, and mortality review is but one of the necessary components of a comprehensive quality assurance program. Consequently, as gratified as we might be by the favorable statistics, one should not assume that mortality data accurately reflect overall quality of care. At Methodist Evangelical Hospital every death is reviewed by the medical staff, and in many instances the cases are presented to and critiqued by the appropriate medical staff department. However, this is only a relatively small facet of our quality assurance program.

Although all hospitals are required by the Joint Commission on Accreditation of Health Care Facilities to have an effective quality assurance program, the program currently in operation at Methodist Evangelical Hospital is one of the most comprehensive and effective systems that have yet been devised. The process involves reviewing 100% of all hospital admissions against a comprehensive group of standards. Anything that occurs which is not a natural and expected consequence of the patient's disease or therapy is recorded by the professionals who do the screening. These events or occurrences are recorded and subsequently reviewed by the quality care coordinator. Depending on the nature of the event and the number of times it has occurred, the event is reviewed by a peer and appropriate action is taken. No event is too trivial to escape recognition by the professional screeners. It is in this context that we feel quality is realistically assured at our hospital.

Again, we would like to express our gratitude for the opportunity to respond to the mortality data of our hospital.

Sincerely,

E. Dean Grout
President/C.E.O.

Donald T. Varga, M.D.
Medical Director

035/rf

MUHLENBERG COMMUNITY HOSPITAL
GREENVILLE, KENTUCKY

CORRECTED DATA

ALL CAUSES

HEALTH CARE FINANCING ADMINISTRATION DATA (HCFA)	MUHLENBERG COMMUNITY HOSPITAL DATA
848 Medicare Cases	993 Medicare Cases
136 Deaths	105 Deaths (136-31 SNF* = 105)
16% Actual Mortality Rate	11% Actual Mortality Rate
9-16% Range of Predicted Mortality Rates	

CANCER

HCFA DATA	MUHLENBERG COMMUNITY HOSPITAL DATA
38 Medicare Cases	50 Medicare Cases
23 Deaths	17 Deaths (23-6 SNF = 17)
61% Actual Mortality Rate	34% Actual Mortality Rate
18-49% Range of Predicted Mortality Rates	

CEREBROVASCULAR ACCIDENTS

HCFA DATA	MUHLENBERG COMMUNITY HOSPITAL DATA
36 Medicare Cases	48 Medicare Cases
20 Deaths	16 Deaths (20-4 SNF = 16)
56% Actual Mortality Rate	33% Actual Mortality Rate
16-45% Range of Predicted Mortality Rates	

*Skilled Nursing Facility (SNF)

COMMENTS ON THE HCFA MORTALITY DATA

MUHLENBERG COMMUNITY HOSPITAL
GREENVILLE, KENTUCKY

OCTOBER 21, 1987

DATA VERIFICATION

The data used by the Health Care Financing Administration (HCFA) indicates that a total of 136 Medicare patients admitted to Muhlenberg Community Hospital died within 30 days of admission. Of these, 91 patients died while still in the Hospital, while 45 died after discharge from the Hospital.

Of the 45 Medicare patients who died after discharge from the Hospital, 31 patients died on the Skilled Nursing Facility (SNF) at Muhlenberg Community Hospital, 6 patients died at home, 4 patients died in local nursing homes and 4 patients died at other acute care facilities to which they were transferred.

HCFA data indicates a total of 848 Medicare cases at Muhlenberg Community Hospital during 1986, while hospital records indicate 993 Medicare cases. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. HCFA data excludes all but the last admission of beneficiaries admitted more than once during the year and in some cases the last admission is presumed to have occurred at another hospital. It is also presumed that some beneficiaries were excluded from the HCFA data base because Medicare billing was delayed due to billing procedures for beneficiaries with potential black lung benefits. These claims are first required to be billed to the U.S. Department of Labor prior to a claim being submitted to Medicare. Billing delays from 2-3 months are not uncommon. Therefore, some 1986 cases would not have been submitted to the Medicare Intermediary until 1987.

REMARKS

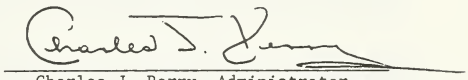
In two(2) of the diagnostic categories recorded by HCFA, the Hospital's actual mortality rate falls outside the range of actual predicted mortality. After adjusting upward the actual number of Medicare cases and excluding Skilled Nursing Facility (SNF) deaths, the number of categories for which the actual mortality rate is outside the range of predicted mortality rate falls to 0.

FACTORS RESULTING IN HIGHER-THAN-AVERAGE MORTALITY

Muhlenberg Community Hospital has an attached SNF, therefore we treat a significantly larger number of terminal, chronically ill patients which would account for a higher-than-average mortality rate, especially for patients with terminal cancer. At least 13 of the 23 deaths recorded by HCFA in the Cancer category had already developed metastases, and their stage of illness was so advanced that death was anticipated irrespective of whether or not they were admitted to the Hospital or SNF for terminal care. Most of these patients had already had oncology and hematology consults elsewhere and had received aggressive treatments and/or therapies.

At least 13 of the 20 deaths recorded by HCFA in the Cerebrovascular Accident category had Do Not Resuscitate (DNR) orders as a result of the physician following the patient's and/or family's wishes with respect to no extra-ordinary efforts.

In the Gastrointestinal Castrophies category, Muhlenberg Community Hospital's actual mortality rate was 33% with the range of predicted mortality rates being 4% to 38%. Seven(7) deaths were recorded by HCFA in this category. Six(6) of these deaths occurred in the Hospital and one(1) occurred at a local nursing home within 30 days following discharge from the Hospital. Six of the seven deaths were due to other causes unrelated to the reason the patient was hospitalized (e.g. gastrointestinal castrophies), with the causes being cardiorespiratory arrest, cardiac dysrhythmia, bronchopneumonia and congestive heart failure. The average age of patients who died in this category was 82 years.



Charles J. Perry, Administrator

NKC, INC.
P.O. Box 35070 • Louisville, KY 40232-5070
(502) 562-8000

October 20, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Hospital ID NUMBER 180088

Dear Dr. Roper:

NKC Hospitals, Inc., (Norton Hospital and Kosair Children's Hospital) has reviewed the mortality information which HCFA has released about our hospitals.

We believe it is important to recognize that mortality figures are not the sole indicator of quality.

We would further emphasize the questionable validity of drawing any conclusions from statistics in diagnostic categories that include very few cases.

While the NKC hospitals rank below or well within the predicted percentage range of Medicare patients who would be expected to die of all causes as well as in specific categories, we feel it is pertinent to note that the mortality figures do not account for intensity or severity of patient illness.

The September 1, 1987 Federal Register's Department of Health and Human Services section implies that very few hospitals in this region deal with as many critical illnesses as do the NKC hospitals. (Table 3C in the final rule on changes to the inpatient hospital prospective payment system lists each hospital's case mix index.) A large percentage of the Medicare patients who died here came to us with end-stage illnesses.

Therefore, no conclusions about quality care should be drawn from these figures.

Thank you for the opportunity to submit these comments.

Sincerely,

Wade Mountz
Acting President and
Chief Executive Officer

0085u/1je

KY 81

NKC is a multi-hospital health system formed to achieve excellence in patient-centered care

OHIO COUNTY HOSPITAL

COMMENTS ON THE HCFA MORTALITY DATA

Ohio County Hospital has reviewed in detail the data used by HCFA in establishing and calculating our mortality data. Several items need to be noted. HCFA's data indicates that 577 Medicare patients were admitted to our hospital in 1986. Our records indicate that 935 Medicare patients were admitted. Presumably this discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Unfortunately, we have no way of verifying the accuracy of HCFA's data in this regard.

HCFA's data also shows that 102 patients died within 30 days of admission to Ohio County Hospital. Of these, 72 died while patients at our hospital and 30 died after they left the hospital. In reviewing these deaths, hospital records indicate that five patients actually did not die in this hospital, but rather, had been transferred to other hospitals where they died, in one case 20 days after transfer. Correcting these discrepancies would reduce the HCFA data to 572 patients and 97 deaths, for an overall revised mortality rate of 17%, at the upper end of the predicted mortality range.

In addition, of the five deaths which should have been attributed to other facilities, four of them were Severe Acute Heart Disease cases and one was a Gastrointestinal Disease case. Consequently, the mortality rates in these categories would be reduced to 58% and 4% respectively.

With these corrections to the data, there remains two areas where the hospital's mortality rate exceeds the calculated mortality rate range: Cancer and Severe Acute Heart Disease. Relative to these two areas several items should be considered:

Our hospital sees a high number of patients who are in the end-stages of terminal cancer. Patients in the earlier stages are sent out to other facilities where they receive more indepth treatment, including chemotherapy. Once alternative measures fail, the patients are subsequently admitted to our facility, essentially to die. Of the cancer patients who died here in 1986, all but one patient had been previously diagnosed and treated for cancer. During their stays, all patients were considered terminal and death was considered an anticipated possibility.

A large percentage of our hospital's transfers are for heart related complications. Although transfer status was one variable in HCFA's predicting model, it is not true that only the "sickest" patients are transferred. In fact, the patients with the liklihood of being benefited from more intense treatment measures not available at our facility are the ones that are transferred.

1211 Main Street, Hartford, Kentucky 42347 • (502) 298-7411

CHIO COUNTY HOSPITAL
DISCREPANCIES IN HCFA DATA - PATIENTS TRANSFERRED OUT AND WHO DIED IN OTHER HOSPITALS

1986 Data

1. (HS) [redacted]
2. (HS) [redacted]
3. (HS) [redacted]
4. (HS) [redacted]
5. (GI) [redacted]

OWENSBORO - DAVIESS COUNTY HOSPITAL

(502) 926-3030 • P.O. BOX 2799 • OWENSBORO, KENTUCKY 42302

Medicare Provider Number 180038

October 26, 1987

Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Sirs,

Owensboro-Daviess County Hospital's mortality percentages were within HCFA's 1986 predictions for Medicare patients. However, we at Owensboro-Daviess County Hospital feel that these percentages are not in themselves measures of hospital performance.

For example:

1) We are a regional acute care facility, thus providing more advanced technological services and treatments. Consequently our severity of illness case load is increased.

2) The rise in the aging population, coupled with the lack of regional long term care facility beds at the time of expected hospital discharge, could have significant data base implications when computing mortality rates for a given hospital.

We feel further that HCFA's published mortality rate for America's hospitals reinforces the message, that the issue addressed, is one of ensuring and not simply measuring quality. Therefore, these percentages can be used to better focus on the quality of patient care.

Owensboro-Daviess County Hospital will continue to provide quality patient care. We assure this by ongoing monitoring and evaluation of hospital and physician services.

Sincerely,

James D. Collins, Administrator

PATTIE A. CLAY HOSPITAL

Richmond, Kentucky 40475
Telephone (606) 623-3131

October 26, 1987

Mr. William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Recently HCFA has released mortality figures for hospitals in the U.S. PAC's results seem quite good. However, we feel that additional explanation is necessary.

The range of predicted mortality rates represents the proportion of beneficiaries treated who are expected to have died on the basis of the nationally estimated probability of death for patients who are similar in terms of selected characteristics - namely age, sex, principle diagnosis, prior hospitalizations, transfer status and selected comorbidities.

A small hospital with no specialists is likely to transfer the sicker patients to a facility which has more equipment and specialists. These more critical patients naturally are more likely not to survive, making the more equipped hospital more likely to have a worse mortality rate.

Thus, one can see that the mortality figures have little, if anything, to do with quality of care. While we at PAC are pleased with our low mortality figure, and are proud of the quality of care provided to all our patients, and in particular, its critically ill patients, we want to inform our public that mortality is not a measure of quality, as HCFA would imply by publication of their data.

We will continue to provide the highest quality care to our patients of all degrees of acuity to the best of our ability when our facilities are not extensive enough, we shall, as always, arrange that this additional management be undertaken at another facility of high quality with the additional resources.

We appreciate the support of our community and look forward to continuing to care for you.

Sincerely,

John M. Johnstone, M.D.

Sincerely,

Richard M. Thomas, Administrator

JMJ:RMT:kmd

RED BIRD MOUNTAIN MEDICAL CENTER

HC 69 BOX 700 • QUEENDALE CENTER • BEVERLY, KY 40913
TELEPHONE (606) 598-5135

September 24, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I have received your letter dated September 21, 1987. The information included has been reviewed. According to our records, the information regarding Red Bird Mission Hospital (ID # 180114), is correct.

If I can be of further assistance, please do not hesitate to contact me.

Very Truly Yours,

Rev. Gerald B. Kinney,
Executive Director

GBK/bah

REGIONAL MEDICAL CENTER
MADISONVILLE

Regional Medical Center
Hospital Drive
Madisonville, Kentucky 42431
(502) 825-5100

October 20, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper,

This letter contains our comments on the HCFA mortality data for Regional Medical Center of Hopkins County (#180093), transmitted to us with your letter of September 21, 1987.

We must emphasize that, even though our mortality figures fall well within the predicted ranges, an appropriate assessment of any hospital's performance is dependent upon many variables, particularly severity of illness, and requires a review of many quality indicators of which mortality is but one. The material used in the HCFA predictive model failed to consider a number of factors that can have a significant impact on mortality, including the patient's general health status, his psychological condition, the family or other support available to him, and the stage of development and severity of the patient's specific or multiple illnesses. We hope future HCFA information will take more of these variables into consideration.

In each of the diagnostic categories, the hospital's actual mortality rate falls within the range of predicted mortality rates. Even though our rates are within the predicted range, it is important to point out several items that distinguish us from the "average" hospital and subsequently the "average" patient used in the HCFA model. Among these are the following:

1. Regional Medical Center is a 401 bed, non-profit voluntary hospital providing a full range of services with a strong commitment to community service, charity care and the education of health professionals. As such, we receive more seriously ill patients from a wide area of this part of the state.

2. We are a full service hospital and as such transfer very few patients, including the terminally or acutely ill, to other facilities. As such, we do not see an "average" mix of patients at our facility; we are a referral hospital. We have been designated a "rural referral center" by HCFA since 1983.

3. The complexity of the illnesses of our patients is high. The last published information on Medicare casemix indexes for the year 1986 indicate that our casemix index is 1.2004. This is the ninth highest casemix in Kentucky.

4. We operate an extensive cancer treatment program through the Merle M. Mahr Cancer Center. This facility provides medical oncology, pediatric oncology, radiation oncology, and in conjunction with the hospital, surgical oncology. We have a long commitment to cancer treatment as indicated by the 1972 certification of our Tumor Registry Board by the American College of Surgeons. As a referral source for cancer patients, we treat the more severely ill patient.

5. We operate a broad based cardiology program, including a strong angioplasty and open heart service. Thus, we receive numerous cardiac referrals, many of whom are chronic, severely ill patients.

6. Regional Medical Center is also a major trauma center for this region of Kentucky. We receive the more severely ill and injured, further raising the complexity of illness of our patients.

7. In all probability, a number of our patients' deaths were a significant possibility at the time of admission or could certainly be attributable to factors not considered in the HCFA model.

In conjunction with our multispecialty medical staff, we have an active quality assurance system. Both process and outcome are scrutinized by committees and individual physicians to spot and highlight opportunities for improvement, both concurrently and retrospectively. The institution is committed to maintaining and improving quality of care through such processes. Though limited, the data you have supplied confirm our own reviews that, even given the complexity of cases treated at RMC, our quality is good.

Many organizations, including your own and the American Hospital Association, have pointed out the limitations of the statistical models utilized, of the data itself, and of some of the assumptions underlying the process. We find no need to again address those limitations.

The data used by HCFA indicates that a total of 333 Medicare patients of the 2,791 admitted to Regional Medical Center died within 30 days of admission. Our own records indicate that 4,701 Medicare admissions occurred in 1986. Apparently the discrepancy reflects multiple admissions of individual beneficiaries. Of those Medicare patients, your records indicate that 276 died while they were still a patient in the hospital and 57 died after discharge.

It is not possible for us to duplicate and verify much of the information produced by HCFA particularly as it relates to those patients who died after leaving the hospital. We particularly cannot determine cause of death, only the information that we have available at the time the patient was hospitalized. Importantly, mortality rates do not indicate "cause of death" which could or could not be related to principal diagnosis.

Without detailed information concerning the data available to HCFA to compute the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis. Therefore, except as noted above, we cannot verify that the data presented by HCFA is accurate.

We thank you for the opportunity to comment prior to the release of this information.

Sincerely,

Bob Dampier
Executive Vice President

BD/bsl

Spring View Hospital

Saint Mary Road
Lebanon, Kentucky 40033
Tel (502) 692-3161

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Your letter of September 21, 1987;
Request for Coments regarding
Mortality Data

PROVIDER #: 180024

Dear Dr. Roper:

The purpose of this letter is to provide our hospital's comments regarding the selected mortality information on Medicare patients treated in our facility in 1986.

The comments which we wish to have published for public information are as follows:

"It should be noted that all hospital death rates fluctuate widely from year to year. Consequently, mortality rate data should be standardized for case severity, and data for several years used. The data do not show the source of the patients admitted to Spring View Hospital. Obviously, those patients admitted from nursing homes tend to be more critically ill than those admitted from their own homes. Spring View Hospital has a long history of providing compassionate health-care for geriatric patients and one should expect a higher death rate in that age group. It should be noted also that some patients do not die from their principal diagnosis. Elderly patients, for example, may be admitted for cardiovascular disease but may have several life-threatening problems at the same time, such as high blood pressure, diabetes, or kidney disease. Nevertheless, the data will reflect that this patient was in the heart disease category.

Mortality data can be misleading if there are only a small number of cases in a particular DRG. The smaller the number, the more likely the number may be subject to misinterpretation. While the data presented applies only to the hospital's Medicare admissions, the public may think the data apply to all patients. Additionally, the data do not allow for an interpretation concerning why a patient died or whether the death could have been avoided. Only an examination of the patient's medical record could identify the particular circumstances."

We appreciate the opportunity to review the 1986 data prior to publication, and we are grateful for the opportunity to provide comment.

Sincerely yours,

Robert E. Garrison
Administrator

REG:jh

cc: Chariman of the Board of Trustees
Chief of Staff

Saints
Mary & Elizabeth
Hospital
4400 Churchman Avenue
Louisville, Kentucky 40215

October 27, 1987

William L. Roper, M.D.
Administrator
HEALTH CARE FINANCING ADMINISTRATION
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

The following information for SS. Mary and Elizabeth Hospital is to be attached to the Hospital Specific Report for the period of January 1, 1986, through December 31, 1986:

A three hundred thirty one bed acute care facility, SS. Mary and Elizabeth Hospital treats primarily adult medical/surgical patients. Services (both medical and surgical) address patient needs in the areas of cardiology, family practice, internal medicine, neurology/neurosurgery, orthopedics, ophthalmology, otorhinolaryngology, pulmonary medicine, thoracic surgery, oncology, gynecology, urology/nephrology, and general surgery.

Mortality review is an ongoing process of the Quality Assurance Program at SS. Mary and Elizabeth Hospital. Peer review activities are an essential element of the monitoring of the health care delivery system at the Hospital. During the 1987 Joint Commission on Accreditation of Hospitals survey, hospital review results were evaluated and SS. Mary and Elizabeth Hospital received a full three year accreditation based in part upon the quality of the hospital's Quality Assurance Program and peer review activities.

HCFA supplied mortality data of SS. Mary and Elizabeth Hospital has been reviewed and reported to the Medical Record/Utilization Review Committee and Executive Committees of the Medical Staff, Hospital Administration, the Quality Care Committee, and the Board of Directors.

The overall mortality rate at SS. Mary and Elizabeth Hospital averages 4.3% per month. The percentage of Medicare patients treated at this facility is 53%. Review of the HCFA supplied mortality rates reveals that in only one category did SS. Mary and Elizabeth Hospital exceed the predicted range of mortality. That category, Severe Acute Heart Disease, was reviewed in its entirety with pertinent findigns recounted herein:

- HCFA predicted mortality rates for Severe Acute Heart Disease were 29% to 48%: the SS. Mary and Elizabeth statistic, without explanation, is 50%.

Continuing...

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∘ Three (3) patients expired in the Emergency Department due to full cardiac arrest or as a result of multiple infarctions without transfer to one of the Coronary Care Units. Due to the Medicare Policy Revision 429, March, 1985, p. 210, "An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.", these patients were classified for billing purposes as inpatients and therefore were considered on the HCFA report. However, had these patients been excluded, the Hospital's mortality rate would then be 48%, or within the HCFA predicted range. All of these patients survived less than one hour and sixteen minutes.

∘ Twenty (20) patients (one third of the deaths in this category) were transferred immediately to the coronary/intensive care units, expiring within twenty-four hours. The severity of the patients' illness precluded recovery.

∘ Four (4) patients presented with ruptured abdominal aortic aneurysms. Surgical intervention was initiated on all patients; however, none survived longer than twenty four hours.

∘ Of the twenty seven patients outlined above, (47% of all deaths), twelve had no previous inpatient admission to SS. Mary and Elizabeth Hospital for treatment of this or any other condition. Ten of these twenty seven patients presented in full cardiac arrest.

∘ Length of stay should also be a consideration when evaluating these statistics. Twenty seven (47%) of the patients succumbed to their acute cardiac condition within twenty four hours of hospitalization.

∘ The average age of the patients who expired was 74.4 years. Breakdown by patient age is as follows:

AGE	TOTAL DEATHS	DEATHS OCCURRING WITHIN 24 HOURS	DEATHS OCCURRING OVER 24 HOURS
64 or Less	4	1	3
65-69	8	5	3
70-74	22	11	11
75-79	13	5	8
80-84	7	3	4
85-89	1		1
90-94	2	2	
95-99	1		1

∘ Comorbid conditions (illnesses also present and affecting each patient's ability to recover) were present (as denoted by the physician upon patient discharge) in all but ten cases. Specifics are:

Continuing...

ADDITIONAL COMORBIDITY*	LOS OVER 24 HR	LOS 24 HR OR LESS	ALL DEATHS
One	7	4	11
Two	9	5	14
Three	6	7	13
Four or More	7	2	9

* It should be noted that while the physicians denoted additional illnesses, only those defined as comorbid by HCFA are reported above.

∘ Also to be considered are the number of hospitalizations each patient had undergone at SS. Mary and Elizabeth Hospital. They are as follow:

	LOS OVER 24 HR	LOS 24 HR OR LESS	ALL DEATHS
Only SSME Hospitalization	15	10	25
One other 1986 Hosp.	1	5	6
Two other 1986 Hosp.	2	4	6
Three or more 1986 Hosp.	1	3	4
Last Hosp. 1985	5	4	9
Last Hosp. 1984	4	1	5
Last Hosp. 1983 or before	2	1	3

∘ There were nineteen (19) patients designated as "No Code" at the families' request. Three patients in this category expired within thirty days of being discharged. The first patient was treated for an acute myocardial infarct with three significant comorbid conditions (as defined by HCFA) and discharged after a length of stay of ten days. The second patient was transferred to a skilled nursing facility after the family requested no further treatment due to the cardiac arrest and the presence of four significant comorbid conditions, following a thriteen day length of stay. The third patient expired, having been discharged following a seven day length of stay for an acute myocardial infarction and two significant comorbid conditions. The patient was advised by physicians to undergo angioplasty, but refused this additional treatment.

The opportunity to provide an explanation to the HCFA Hospital Specific (mortality) Report is appreciated.

Thank you,

SS. MARY AND ELIZABETH HOSPITAL

Raymond W. Leitner
Chief Executive Officer

RWL:mdn

Hospital Provider #180037

St. Anthony Medical Center

1313 St. Anthony Place
Louisville, Kentucky 40204-1749
502 587-1161

October 27, 1987

Mr. Harvey Brook
Health Standards & Quality Bureau
Health Care Financing Administration
Room 2-D-2
Meadows East Building
6300 Security Boulevard
Baltimore, MD 21207

Dear Mr. Brook:

Enclosed are our comments pertaining to mortality data for St. Anthony Medical Center that was requested in Dr. William L. Roper's letter dated September 21, 1987. Our Medicare provider number is 180085.

If anything further is needed, please do not hesitate to call me.

Thank you.

Sincerely,

Michael J. Budnick
President

Enclosure

cc: William L. Roper, M.D.

MJB/ld

A division of
Sisters of St. Francis
Health Services, Inc

Comments on the Health Care Financing Administration (HCFA) Mortality Data
Medicare Provider Number 180085

The information from HCFA shows St. Anthony Medical Center to be within the range of predicted mortality rates for all diagnostic categories from all causes. This is directly related to the commitment of our physicians and staff to quality patient care. Numerous programs are in place to help ensure that this occurs.

Of the cases reported to us, 24 patients did not expire while in St. Anthony. There were two patients listed by HCFA as having died at St. Anthony but who were never in the Medical Center.

At St. Anthony, there are a number of factors which offset our patient services profile. We are treating a high percentage of Medicare patients who have multiple system diseases present. Our HealthWise 65 program has enrolled thousands of members. We are also known as a regional cancer center with the Radiation Therapy Center at St. Anthony. The Medical Center also treats a large number of patients with pulmonary, acute and chronic heart disease. We feel that our current patient populations and the service offered demonstrate how well our patients are served. The medical staff prides itself on their commitment to patients and families. If we can interpret the data as being accurate and reliable, then we can conclude we are providing appropriate patient care.

St. Elizabeth Medical Center
North Unit - Covington, Kentucky
South Unit - Edgewood, Kentucky

October 26, 1987

Mr. Harvey Brooks
Health Standards and Quality Bureau
2-D-2 Meadows East Bldg.
6300 Security Blvd.
Baltimore, M.D. 21207

Dear Mr. Brooks:

Enclosed please find comments from St. Elizabeth Medical Center, Covington/Edgewood, Kentucky for the Health Care Financing Administration (HCFA) Mortality Data, that is being compiled for publication in December, 1987's report.

If you have any questions or comments, please address them to me by calling (606)292-4321.

Thank you.

Sincerely,

Michael J. Walters

Michael J. Walters, Ph.D.
Vice President of Marketing
and Strategic Planning

MJW/ms

Medicare Provider No.: 180035

enclosures

HCFA MORTALITY DATA: COMMENT

In 1986, St. Elizabeth Medical Center had a mortality rate within the range of predicated death rates in all of the 16 diagnostic categories, as well as in the overall mortality rate.

Errors in HCFA Calculations

In its presentation of 1986 Medicare mortality data for each U.S. hospital HCFA provides:

1) the actual number of Medicare patients treated at the hospital overall and for each of 16 diagnostic categories,

2) the mortality rate for each of these categories, as well as the overall rate, and

3) the actual listing of patients who have died in each specific diagnostic category.

Because HCFA has provided each hospital with the actual listing of deaths, it is possible to verify their calculations. A number of arithmetic errors have been made by HCFA in calculating St. Elizabeth Medical Center's mortality rates. First, the data provided by HCFA show that 4,001 Medicare patients were admitted to St. Elizabeth in 1986. The patient listing provides the names and patient characteristics of 487 who died within 30 days of admission. This mortality rate calculates to 12%, not the 13% that HCFA reports. Secondly, in five specific diagnostic categories, HCFA's calculated mortality rate for St. Elizabeth Medical Center is at least 1% higher than what actually occurred. These five categories are:

1. Cerebrovascular accidents
2. Gastrointestinal catastrophes
3. Severe acute heart disease
4. Metabolic/Electrolyte disturbance
5. Pulmonary disease

Admissions vs. Individuals

St. Elizabeth Medical Center's records indicate that 6,168 Medicare admissions occurred in 1986. The discrepancy between 4,001 and 6,168 reflects the fact that HCFA only identified the last hospital admission of the year for all Medicare patients, not every Medicare admission during the year. Therefore,

although there were 4,001 individual Medicare patients at St. Elizabeth Medical Center in 1986, each of these individuals had an average of 1.54 admissions. Some of these 4,001 individuals had multiple admissions for different diseases. For example, one Medicare patient admitted in November, 1986 for a pulmonary embolus was readmitted a month later for a urological disorder. However, in this case HCFA used only the December admission in calculating the medical center's mortality rate.

This discrepancy has a direct bearing on calculating and interpreting the overall mortality rate as well as the mortality rate for each of the sixteen diagnostic categories used by HCFA. For example, St. Elizabeth Medical Center's overall mortality rate for Medicare patients in 1986 is 12.2%. This rate is based on the last admissions of the 4,001 individuals. However, if the mortality rate were based on all Medicare admissions during 1986, then the actual mortality rate is 7.9%.

To understand mortality rates in any U.S. hospital, it is important to note that acuity levels among patients in U.S. hospitals have increased in the last few years. Medicare patients, in general, are considerably more ill than in the past due to consequences of the prospective payment system. Hospitals and physicians have adapted to DRG's by emphasizing shorter lengths of stay, greater use of outpatient and surgical services and increased delivery of home health services.

It is also important to understand that the hospital's overall mortality rate, using HCFA's model, is a composite of its mortality rate in individual diagnostic categories. Since the death rate is understandably higher in some categories (e.g. severe acute heart disease) compared to some other categories (e.g. orthopedics), hospitals treating a higher percentage of high risk patients than other hospitals will normally have a higher overall mortality rate.

Other Critical Factors

In addition to this serious limitation in how admissions are counted by HCFA, there are a number of critical factors which are not included in HCFA's statistical model in estimating the risk of death. One of the most critical, if not the most important factor in accurately predicting mortality rates for different disease categories, is the severity of the patient's illness at the time of admission. The mortality rates of large urban hospitals, such as St. Elizabeth Medical Center which treat many severe, complicated cases, can not be adjusted in HCFA's model.

Another factor not included but which has often been shown in scientific research to influence mortality rate is the socio-economic status of the patient. Patients from lower income groups tend to have less access to medical resources outside of an institutional setting. For example, upon hospital discharge,

many poor, elderly patients cannot be readily transferred to a nursing home or a hospice or have the medical support they need in their own homes.

In 1986, 7.7% of St. Elizabeth Medical Center patients were indigent compared to only 4.5% for all hospitals in the Greater Cincinnati area. These data strongly suggest that St. Elizabeth treats a larger percentage of poor patients compared to other hospitals in our area. Of the 487 Medicare patients who died after being admitted to St. Elizabeth Medical Center in 1986, 409 died while still a patient of the hospital, while 78 or 16% of all Medicare deaths occurred after discharge. Given this percentage of Medicare patients who died after discharge (16%), it is important that measures of socio-economic status be included in future attempts by HCFA to predict mortality rates.

SUMMARY:

Medicare Mortality Rates at St. Elizabeth Medical Center

These major limitations in the large number of admissions excluded and in the omission of key factors such as severity of illness and socio-economic status which are related to the risk of death reduce the meaningfulness of HCFA's data. Nevertheless, St. Elizabeth Medical Center's mortality rates are similar to statistically established averages for other hospitals in the U.S. using HCFA's limited statistical model, which accounts for the age, sex, prior hospitalizations, transfer status and comorbid conditions of each patient. Again, factors such as the patient's severity of illness, psychological condition, socio-economic status, and family support are not included in HCFA's model, although many experts attest to the importance of these factors in predicting one's risk of death.

St. Luke Hospital, Inc.
85 North Grand Avenue
Fort Thomas, Kentucky 41075 (606) 572-3100

John D. Hoyle, M.H.A.
President and Chief Executive Officer

October 22, 1987

Hospital No. 180001

Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

St. Luke Hospital is pleased with the Health Care Finance Administration (HCFA) report that confirms that all deaths of Medicare patients came within the range of predicted mortality rates.

The Medical Staff, supported by hospital staff members, has ongoing quality assessment, monitoring, and analysis through the following committees: Quality Assurance, Tissue, Medical Records, Pharmacy and Therapeutics, Institutional Review Board, Safety, Laser Safety, Radiation Safety, Utilization Review, Transfusion Review; its Quality Assurance Council and Medical Department meetings.

Additionally, the hospital employes 6 persons full time whose sole function is to assess quality on a continual basis. Ninety management persons are also involved in continual quality analysis and are further aided by numerous employees who check, audit and compile data for use by the Committees and Managers. The data collected, medical records reviewed and reports generated follow a methodical path and are reported on an ongoing basis to the Medical Staff, Board of Directors, Administration and are also reviewed by inspectors from the State Office of Licensure and Regulation and the Joint Commission on Accreditation of Healthcare Organizations.

At St. Luke Hospital, quality care is foremost in the minds of the physicians and hospital staff alike and we commit considerable resources to that goal.

Unfortunately, the HCFA data is based on national statistics and limits the amount of information gathered on each patient. For example, in our review of the deaths in the HCFA study, we found that 11% had died outside of St. Luke Hospital, at their home, a nursing home or another hospital. 62% were in serious or critical condition upon admission; 30% had cancer and an additional 10.8% had cancer as a secondary cause of death. 76% were considered terminal and families requested that heroic or resuscitative measures not be used in treatment; and the average age of the deceased was 78 years. Nowhere are those facts reflected in the HCFA data.

Cancer

(1) 60% were in serious or critical condition upon admission. (2) the vast majority of these patients had at least two other co-existing conditions, such as kidney failure and vascular disease. (3) Average age - 75 years. (4) In 80% of the deaths, the families requested that heroic or resuscitative measures not be used in treatment.

Cerebrovascular Accidents

(1) 95% were in serious or critical condition upon admission. (2) All of these patients had other co-existing conditions such as terminal cancer and respiratory failure. (3) Average age - 77 years. (4) In all these deaths, the families requested that heroic or resuscitative measures not be used in treatment. (5) In ten of the twenty deaths, the patients were comatose upon admission.

Gastrointestinal Disease

(1) 50% were in serious or critical condition upon admission. (2) Each patient had at least three severe co-existing conditions, such as liver failure and shock. (3) Average age - 80 years. (4) In 80% of the deaths, families requested that heroic or resuscitative measures not be used in treatment.

Gastrointestinal Catastrophes

(1) 44% of these patients were admitted in serious/critical condition. (2) All of these patients had other conditions affecting their prognosis, such as kidney failure and liver disease. (3) Average age - 74 years. (4) In 77% of these cases, the family requested no further heroic or resuscitative measures. (5) All patients suffered rapid deterioration despite aggressive treatment for these diseases.

Urologic Disease

(1) 40% of these patients were admitted in critical condition. (2) All of these patients had other significant conditions influencing their eventual outcome, such as heart failures. (3) Average age - 76 years. (4) In 80% of these cases, the family requested that no further heroics or resuscitative measures be employed. (5) Of significance is that 2 of these patients died waiting for nursing home placement.

Low-Risk Heart Disease

(1) 50% were in serious or critical condition upon admission. (2) All of these patients had other significant conditions, such as metastatic cancer. (3) Average age - 75 years. (4) In 79% of the deaths, the family requested that no further heroic or resuscitative measures be taken. (5) A substantial number of those patients were re-admitted from one to three times in 1985-86, indicating the terminal nature of their diseases and aggressive treatments employed prior to death.

Severe Chronic Heart Disease

(1) 55% of these patients were in serious or critical condition upon admission. (2) 27 of these records documented other significant conditions influencing their outcome, such as kidney disorder and metastic cancer. (3) Average age - 77 years. (4) In 72% of these cases the family requested that no further heroic or resuscitative measures be employed. (5) The majority of these patients had an average 1 to 3 re-admissions during 1985-1986, indicating the chronicity of their diseases and multiple successful attempts at stabilization and improvements of the quality of the patient's life. One patient expired at home and one patient in a nursing home.

Severe Acute Heart Disease

(1) 58% were in serious or critical condition upon admission. (2) All but 3 patients had other significant conditions, such as diabetes. (3) Average age - 78 years. (4) In 53% of these deaths, the family requested that no further heroic or resuscitative measures be instituted. (5) A majority of these patients were treated very aggressively to include such measures as pacemaker insertions, Swan Ganz placement and ventilator support.

Metabolic/Electrolyte Disturbances

(1) 66% were in serious or critical condition on admission. (2) All patients had other significant conditions, such as cancer and diabetes. (3) Average age - 74 years. (4) In 83%, the family requested that no further heroic or resuscitative measures be employed. (5) One of these patients expired in a nursing home.

Orthopedic Disorders

(1) One of the three patients was in serious condition upon admission. (2) All

Orthopedic Disorders - (Continued)

patients exhibited other significant conditions: two had terminal cancer and one was admitted in a comatose state from a nursing home. (3) Average age - 74 years. (4) In two of the three cases, the family requested no further heroic or resuscitative measures.

Pulmonary Disease

(1) 78% were in serious or critical condition upon admission. (2) In all but one death, the patients had numerous severe co-existing conditions, such as heart failure and stroke. (3) Average age - 82 years. (4) In 80% of the deaths, the families requested that heroic or resuscitative measures not be used in treatment. (5) 28% of the deaths occurred after the patient was discharged to a nursing home or other institution.

Renal Disease

(1) 50% were in serious/critical condition at the time of admission. (2) All patients had other significant conditions and the intensity of services provided far exceeded that expected for an average Medicare patient. (3) Average age - 82 years. (4) In all of these cases, the family requested no further heroic or resuscitative measures be employed.

Sepsis

(1) In all cases, the patients were serious or critical upon admission. (2) All patients had other severe conditions which were life-threatening, such as massive pneumonia and shock. (3) Average age - 81 years. (4) In all cases, the families requested that heroic or resuscitative measures not be used in treatment.

Severe Trauma

(1) All patients were admitted in significant risk because of their advanced age and conditions, such as respiratory failure. (2) Average age - 88 years. (3) In 66% of these cases, the family requested no further heroics or resuscitative resources be employed.

Unknown

(1) 49% of these patients were admitted in serious or critical condition. (2) All of these patients had other significant conditions, such as heart disease and metastic cancer. (3) Average age - 78 years. (4) Our case mix of patients in this group exhibited an unusually high number of both chronic and acute disease states, which required an unusually high intensity of services during their stay. 17% of these patients expired after discharge. (5) In 71% of these cases, the family requested that no further heroics or resuscitative measures be employed.

Sincerely,

John D. Hoyle
President

JDH:PC

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COMMENTS ON THE HCFA MORTALITY DATA
T. J. Samson Community Hospital
Glasgow, Kentucky 42141

In response to the HCFA Mortality Data, the TJSCH makes every effort to insure the provision of the highest quality of care to all patients. The quality of care provided is of the utmost concern to the hospital's governing board, management, and medical staff.

Although we feel consumer access to data of this respect is valid and useful, we do feel several points should be stated:

1. HCFA data does not measure severity of illness, whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, or the patient's psychological state or general health status.

2. HCFA data are not all-inclusive. The mortality rates apply only to Medicare patients, and are calculated using only deaths that occurred within 30 days of the last admission of a Medicare beneficiary to a hospital during 1986. Some of the deaths represent those that occurred elsewhere after discharge from the hospital and may have been from a cause having no relation to the last hospital admission.

3. HCFA data groups patients based on principal diagnosis rather than the actual cause of death.

In one high risk diagnostic category, Sepsis, the hospital's actual mortality rate fell outside of the predicted mortality rate.

The medical records of those nine patients with the principal diagnosis of sepsis were studied.

Conclusions were as follows:

- All nine patients had severity of illness with comorbid and complicating conditions which could be equally causative of death, four having carcinomas.
- Three of the patients were transferred from nursing homes.
- One patient had been cared for by a Home Health Agency prior to admission.
- One patient was unresponsive on admission.
- One patient was preterminal.

The average age of the nine patients was 76.6 years.

Medical record review was also performed in three low risk categories; Ophthalmologic Diseases, Orthopedic Diseases and Urologic Diseases. These reviews were performed not because the rate exceeded HCFA predicted norms, but rather to determine if in fact, a low risk diagnosis had resulted in mortality. Findings in all three cases were that the principal diagnosis was not the cause of death, therefore reflecting incorrect mortality data.

Such organizations as the American Hospital Association and Joint Commission on Accreditation of Healthcare Organizations are investigating methods of evaluating hospital quality that rely on measures other than mortality rates and TJSCH looks forward to the results of these efforts and feels the public will have a more accurate picture of the actual quality of care provided by an institution.

H. Glenn Joiner,
Administrator

Hospital ID Number - 180017

TAYLOR COUNTY HOSPITAL
1730 N. Hwy. 289
Campbellsville
Kentucky 42718
(502) 465-3561

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Re: Taylor County Hospital
Provider # 180087
Mortality Rates

This letter is in reply to the mortality rates to be published by Health Care Financing Administration, (HCFA).

Taylor County Hospital has reviewed the data provided by HCFA and has the following comments regarding the accuracy of data and publication of mortality rates:

1. HCFA reporting of mortality rates to the general public is a slap in the face to the quality of health care in this country. Based on the millions of dollars that our government has supported the technology, quality of care, and increasing life expectancy over the past several years now becomes the culprit to disgrace the deliverer of health services by misleading the general public with statistics and not providing the variable information related to the mortality rates such as average age of the patients, severity of illness, where the patient died, or even the patients right to die within the health care setting, etc. Mortality data published will affect healthcare deliverers because what the public perceives is reality and not the written intent of the government to inform the public with data they do not understand. Therefore, the public will interpret the Mortality rates as a quality of care issue regardless of the intent to provide general information.

2. Mortality Data for Non Hospital Admissions:

   HCFA has credited hospitals with mortality statistics within thirty days (30) of admissions for patients that deceased in other healthcare facilities, such as Nursing Homes, locations outside the hospital, or even credited more than one hospital with the same mortality statistic for patients admitted to more than one hospital within 30 days of their death.

   Of the ninety two (92) deaths credited to our facility, twenty seven (27) or twenty nine percent (29%) were outside of our facility. Of these twenty seven (27), fifteen (15) or fifty six percent (56%) were discharged to a Nursing Home where they deceased. Attached is a list of the reasons for death in the Nursing Home. The average age of those patients that deceased in the Nursing Home was eighty (80) years of age.

Recommendation: We request that this variable data be published by HCFA in order to clarify the mortality statistics.

The remaining twelve (12) of the twenty seven (27) deaths or forty four percent (44%), that died outside our hospital were discharged to their home. We have no way of verifying the real cause of death other than contacting the family. We do not believe that this would be kosher. Therefore this mortality statistic is not valid for HCFA to use in its mortality rates for our hospital.

Recommendation: We request that all twenty seven (27) cases be deleted from the mortality statistics for our hospital.

3. Total Cases:

HCFA has reported 756 cases related to all causes. The total case count shows that there were 869 unduplicated Medicare admissions in 1986 to Taylor County Hospital. Attached is a list that shows the total Medicare admissions. The mortality rate computed by HCFA is twelve percent (12 %) (92 deaths / 756 cases). The mortality rate computed by the hospital is eleven percent (11%) (92 deaths / 869).

The mortality rate computed by the hospital by excluding deaths outside the hospital would be seven percent (7 %) (65 deaths / 869 cases). The adjusted rate based on HCFA data excluding deaths outside the hospital would be nine percent (9 %) (65 deaths / 756).

Recommendation: We request that HCFA adjust its total case count to agree with the unduplicated count verified by the hospital from 756 to 869 cases. We also request that HCFA provide the general public with the mortality rates excluding deaths outside the hospital in order to accurately inform the public regarding mortality rates.

4. Variable Data Affecting Patient Mortality Rates:

One important variable statistic not computed by HCFA and relates to the quality of care is the age of the patients. The average age of the ninety two (92) patient deaths credited to our hospital is eighty three (83) years of age. This variable is significant to clarify the statistics reported by HCFA.

Another important variable, not considered by HCFA, is related to those catastrophic cases and their right to die in the health care facility that can only provide the level of care and comfort in the last days of life.

Recommendation: We ask that HCFA publish these variables related to our facility.

5. HCFA Mortality Rates:

The actual mortality rates as proposed have three errors noted. The following represents those errors in the computation:

Diagnostic Category	# of Cases	# of Deaths	Mortality Rate Per HCFA	Mortality Rate Per Hosp
HM Severe Chronic Heart Disease	28	7	32 %	25 %
ME Metabolic/Electrolyte Disturbances	23	5	26 %	22 %
PN Pulmonary Disease	65	15	18 %	23 %

Recommendation: We ask that HCFA correct these mathematical discrepencies before publication of the mortality rates.

6. Reporting Mortality Raw Data vs Percentages:

It is apparent that reporting percentages of mortality rates distorts the impact of the intent of the numbers to the general public. The current table is confusing on how HCFA computed the mortality percentages. In addition, percentages do not reflect the real data being reported. We recommend that HCFA report the number of deaths by diagnostic category so that the general public can evaluate the real impact with the raw data rather than distorting the data with unrealistic percentages computations.

We recommend the following table for publication:

Diagnostic Category	# of Cases	# of Deaths	Mortality Rate	Range of Predict. Mortality Rates
All Causes	862	92	11 %	8 to 15 %
CA Cancer	50	12	24 %	12 to 38 %
CE Cerebrovascular Accidents	6	2	33 %	4 to 67 %

This example table will allow the general public to evaluate the impact of the percent by noting the actual number of deaths in relation to total cases.

Recommendation: We recommend that HCFA provide the actual deaths in the table of statistical data.

We appreciate the opportunity to respond to the Mortality Rates to be published. We hope HCFA will take into account our response and correction to the data accumulated. If you have any questions or need additional information, please call at 502-465-3561 Ext. 201.

Sincerely,

David R. Hayes

David R. Hayes
Administrator

cc: Congressmen & State Representatives
Kentucky Hospital Association
American Hospital Association

The Medical Center AT BOWLING GREEN
A COMM HEALTH CORP SUBSIDIARY

John C. Desmarais
PRESIDENT

Carrel K. Sumner
VICE PRESIDENT - OPERATIONS

Gary J. Hoefler
VICE PRESIDENT - FINANCE

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen,

We have reviewed the data submitted from the Health Care Financing Administration in regard to mortality information of acute care hospitals to be published in December, 1987. This mailing also seeks comments from hospitals in regard to the data.

While our hospital falls within the predicted range of mortality rates, I feel the potential exists for misinterpretation of the statistics as presented.

Since the data does not contain a severity of illness index, the statistics are likely to be skewed toward the lower end of the scale for those hospitals who typically treat only the less acute injuries and illnesses. Those hospitals serving as referral centers could experience higher mortality rates due to the higher ratios of patients treated who are seriously ill and need the services of such a center.

Our hospital is a regional referral center for a ten-plus county area in Kentucky. We receive patients who are severely ill from smaller hospitals in surrounding areas as well as nursing homes who often transfer patients when they become critical. Over the years we have postured ourselves to have the technology and trained staff to deal with serious illness and have dedicated many resources to the treatment of heart disease, cancer and trauma patients.

As a result of this and the availability of medical specialists in our community which are not otherwise covered in the region, we receive a high percentage of those patients who are gravely ill and require high tech diagnostic services and treatment. Under these circumstances, it is difficult to compare mortality rates with the raw data from all hospitals.

P.O. Box 56 Bowling Green, Kentucky 42102-0056 (502) 781-2150

I am sure you have received similar comments from other hospitals who have this experience and I would hope that a reliable severity index could be developed which would take into account the nature of the patients served by a hospital. It may be possible to refine the predicted ranges based on the scope of services and acuity levels of the patients served.

Thank you for your consideration.

Sincerely,

Carrel K. Sumner
Vice President - Operations

CKS/mmb

UNIVERSITY OF KENTUCKY

ALBERT B. CHANDLER
MEDICAL CENTER
LEXINGTON, KENTUCKY 40536

UNIVERSITY HOSPITAL
OFFICE OF EXECUTIVE DIRECTOR
PHONE 606-233-5767

October 19, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

We wish to express our appreciation for the opportunity to respond to the HCFA determined Medicare mortality rates prior to their publication and release to the public. This opportunity to critically review the data and to evaluate the cases has enabled a constructive quality review of our care programs and will improve our ability to assist in providing the public with accurate information regarding our programs. We endorse HCFA's desire to more fully inform the public regarding health care programs.

We have carefully compared our quality assurance data with the data provided (see attachment one). Using HCFA's methodology, we have identified 254 cases and 16 deaths not included in HCFA's data. All the deaths identified by HCFA accurately represent University of Kentucky patients and their causes of death. Please note that the above additional cases lower our mortality rate in ten catagories. It increases our mortality rate in one catagory, severe trauma.

We respectfully differ from the HCFA methodology. We believe that a case of cancer treated in January of one year should remain in the cancer caseload even if the patient died of severe trauma in December. HCFA's methodology removes successfuly treated cases that die from other diseases in subsequent stays. This artificially elevates mortality rates. Attachment one, UK's methodology, identifies patients who were seen and treated for totally different diseases during separate stays. We believe this methodology provides a much more accurate evaluation of the quality of care provided by the University of Kentucky Hospital as a regional referral center.

The University Hospital maintains an active, in depth quality assurance program. The majority of the deaths identified by HCFA had already been individually reviewed as part of our ongoing quality assurance program. No significant deviation from standards of care were identified. Given the acuity of our patients and the regional referral status of the University Hospital, we consider the mortality statistics provided to be a positive testimony to the quality of our care programs.

To emphasize the patient mix problems faced by University Hospital, we carefully analyzed all deaths in catagories where we were above the 50th pecentile of HCFA mortality rates. That information is enclosed in Attachment Two.

In summary, we hope you will be able to update your statistics before publication using our more accurate data. We anticipate that you will give serious consideration to our proposed modification of your methods which would provide a more accurate reflection of hospital mortality statistics. We are proud of our programs and role as the tertiary care referral center for Eastern Kentucky. The published mortality statistics augmented by our acuity statistics are testimony to the quality of our programs and documentation of our service to Kentucky.

Sincerely,

Frank A. Butler
Director, University Hospital
Medicare Provider Number 18-0067

FAB/par
enclosures

AN EQUAL OPPORTUNITY UNIVERSITY

MEDICARE MORTALITY RATE 1986

DIAGNOSTIC CATEGORY	HCFA'S METHODOLOGY						Range of Mortality Rates	UK'S METHODOLOGY					
	# CASES		# DEATHS		MORTALITY RATE			# CASES		# DEATHS		MORTALITY RATE	
	HCFA	UK	HCFA	UK	HCFA	UK		HCFA	UK	HCFA	UK	HCFA	UK
Cancer	173	224	32	40	18%	18%	22 to 40 %	173	296	32	40	18%	14%
Cerebrovascular Accidents	53	78	12	14	23%	18%	18 to 43 %	53	85	12	14	23%	16$
Ophthalmologic Disease	34	34	0	0	0%	0%	0 to 32 %	34	34	0	0	0%	0%
Gastrointestinal Catastrophies	37	41	15	15	41%	37%	13 to 42 %	37	55	15	15	41%	27%
Gastrointestinal Disease	117	133	10	10	9%	7%	4 to 15 %	117	176	10	10	9%	6%
Urologic Disease	61	79	8	8	13%	10%	2 to 16 %	61	86	8	8	13%	10%
Gynecologic Disease	15	15	0	0	0%	0%	0 to 54 %	15	15	0	0	0%	0%
Low Risk Heart Disease	118	134	6	7	5%	5%	2 to 11 %	118	169	6	7	5%	4%
Severe Chronic Heart Disease	42	54	11	11	26%	20%	12 to 37 %	42	67	11	11	26%	16%
Severe Acute Heart Disease	45	51	15	15	33%	29%	24 to 53 %	45	60	15	15	33%	25%
Metabolic/Electrolyte Disturb.	54	60	14	14	26%	23%	11 to 37 %	54	83	14	14	26%	17%
Orthopedic Disorders	105	118	1	1	1%	1%	0 to 8 %	105	131	1	1	1%	1%
Pulmonary Disease	96	110	35	35	36%	32%	14 to 32 %	96	139	35	35	36%	25%
Renal Disease	64	77	5	5	8%	6%	5 to 35 %	64	124	5	5	8%	4%
Sepsis	7	7	5	5	71%	71%	14 to 77 %	7	8	5	5	71%	62%
Severe Trauma	26	26	4	5	15%	19%	4 to 31 %	26	29	4	5	15%	17%
All Other Causes	667	727	47	50	7%	7%		667	867	47	50	7%	6%
Total All Causes	1,714	1,968	220	235	13%	12%	10 to 16 %	1,714	2,424	220	235	13%	10%

KY 107.1

CHARACTERISTICS OF MEDICARE PATIENTS
UNIVERSITY OF KENTUCKY HOSPITAL 1986

	AS-SCORE* SEVERITY INDEX BY %				TRANSFERRED FROM OTHER ACUTE CARE HOSPITALS OR NURSING HOMES		PERCENT OF PATIENTS TERMINAL ON ARRIVAL TO UK	
SEVERITY INDEX FACTOR DX CATEGORY	I	II	III	IV	PERCENTAGE TRANSFERRED	PERCENTAGE UNSTABLE		COMMENTS
GI Catastrophies	0	0	31	69	55%	33%	7%	
Urologic Disease	0	0	1	7	100%	50%	0%	
Severe Chronic Heart Disease	0	*0	18	82	45%	36%	0%	
Pulmonary	6	8	24	62	53%	32%	6%	UK Hospital serves Eastern Kentucky Black Lung patients. Three additional cases were ventilator-dependent at the time of transfer
Sepsis	0	0	20	80	38%	25%	0%	
Severe Trauma	0	2	2	1	20%	60%	0%	

*Acuity scoring system developed by John Hopkins University and Church Hospital

KY 107.2

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT KNOX, KENTUCKY 40121-5520

October 13, 1987

Deputy Commander
for Administration

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The selected mortality figures for Medicare patients treated at Ireland Army Community Hospital, Fort Knox, Kentucky are misleading. Only two Medicare admissions are shown for 1986 and both were civilian emergency admissions. A statistical sample with a size of two does not seem valid. The one death was a civilian emergency patient who was dead on arrival (DOA) at the hospital. While technically the DOA patient died after admission in the hospital emergency room, the statistic of one patient being pronounced dead in the hospital emergency room does little to provide a barometer for quality of care at Ireland Army Community Hospital. In short, your figures concerning mortality at this hospital are meaningless.

HCFA should also keep in mind the fact that Military Hospitals care for many Medicare eligible patients who are also eligible for care at the military hospitals. Medicare eligible patients who are also military eligible beneficiaries will not appear in your studies since Medicare is not billed for the care provided.

Sincerely,

Philip L. Dorsey
Colonel, Medical Service Corps
Deputy Commander for Administration

WCH WAYNE COUNTY HOSPITAL

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

In response to the published data, in which Wayne County Hospital falls within the range of predicted mortality rates, certain items should be noted concerning those areas found to be above this predicted range.

We feel that the data does not accurately reflect many aspects, such as the fact that the diagnostic categories are based upon the principle diagnosis (the condition which initially occasioned the admission), and this is not the cause of death in many cases. As a result of this, in the information for Wayne County Hospital, it seems that some cases were in the wrong category, thus skewing the percentages. Also not accounted for in the death rates are severity of illness, patient socio-economic status, and stage of illness, among others.

In response to the specific areas, the "cancer" category showed an actual mortality rate of 71%. Not considered here, however, is the fact that Wayne County Hospital is a facility that has no admissions for cancer workup or treatment, but is a facility to which these patients are admitted for terminal hospice-type care. The average age of this group was 81 years, and considering these circumstances, this rate is not unexpected.

In the "renal disease" category, which included only three patients, 100% mortality rate was reported. All three of these individuals were end-stage renal disease patients with an average age of 83 years. Again, considering the patient's ages and severity of illness, the results are not unexpected.

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Overall, we feel that the information provided by the Health Care Financing Administration is a useful screening device to be used for enhancing hospital Quality Assurance programs, which is ongoing at Wayne County Hospital. However, the limitations of the data presented must be acknowledged and the individual situations should be considered to gain a good, accurate view of mortality rates at each facility.

Respectfully,

J. Edward Cooper

J. Edward Cooper, F.H.F.M.A.
Administrator

/bjd

H. F. THEZOR, EVCHE., PRESIDENT
(502) 575-2100

WESTERN BAPTIST HOSPITAL
Where your needs come first

2501 KENTUCKY AVENUE
PADUCAH, KY 42001

October 22, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Re: Western Baptist Hospital - Provider Number 18-0104

Dear Dr. Roper:

Western Baptist Hospital thanks the Health Care Financing Administration for permitting us the opportunity to submit comments regarding the Medicare Mortality study prior to the study being made public. We are very concerned about data of this type being made public when, as you have indicated in your letter of September 21, 1987, the data is subject to error and that you do not recommend that the information should be used to make judgments about the quality of care rendered at any hospital.

The data provided by HCFA indicates that a total of 3,043 Medicare patients were admitted to Western Baptist Hospital in 1986. Because the HCFA data only recognizes the last admission for each patient each year, it significantly understates the actual Medicare admissions. Hospital records reflect actual Medicare admissions for 1986 to be 5,110. This difference in the number of admissions used in the study should be considered in order not to overstate and overemphasize mortality rates.

Based on the HCFA data, of the 3,043 Medicare patients admitted to Western Baptist Hospital, 346 patients expired during the 30 days following their admission. Of these 346 patients, 292 died while still hospitalized and 54 died after discharge from the hospital. A review of hospital records on the 54 patients reported as dying after discharge from the hospital identified three patients as having actually died while hospitalized in 1986 and one patient listed as dead is not known to be deceased. While it is impossible to verify all the data in the study, we are very concerned to find four of the 54 cases reviewed to be reported in error. This would suggest the potential of almost a 10 percent error rate in the data.

As a part of the HCFA study, HCFA has developed "A Range of Predicted Mortality Rates" to be used as a comparison against each hospital's actual mortality rate. According to the HCFA data, the overall range of predicted mortality for Western Baptist Hospital is from 8 percent to 14 percent. We are pleased to find that the HCFA study reflects the actual mortality rate for Western Baptist Hospital to be the exact midpoint of the range which is 11 percent. Again, we would like to point out that if all Medicare admissions for the year were used in the computation, the correct rate for Western Baptist Hospital would be less than

7 percent based on the 346 deaths reported in the study. When removing the 54 cases where the patient died after discharge, the actual rate would be less than 6 percent based on actual Medicare deaths in the hospital.

The HCFA study, in addition to providing overall mortality results, breaks each admission and death down into diagnostic categories. We are pleased to find that in each category, except one, our actual mortality rate is well within the predicted range as projected by HCFA. The one category in which Western Baptist exceeds the HCFA range is Severe Trauma. Western Baptist has an actual rate of 18 percent as compared to the HCFA predicted range of 3 percent to 17 percent. Fifteen patient deaths were reported by HCFA in this category. A review of the 15 patients' medical records reveal that, in fact, 11 of the patients died not because of the severe trauma but, rather, because of underlying diseases unrelated to the cause of the trauma. This one category alone, we believe, demonstrated the fallacy of developing mortality information without having complete information on the patients' conditions prior to admission.

In summary, Western Baptist Hospital is gravely concerned about HCFA publishing any form of mortality studies for the following reasons:

...By HCFA's own admission, there is a possibility of error in the results because HCFA in unable to verify all of the data.

...We are concerned that as a result of HCFA publishing a "Range of Predicted Mortality" by diagnostic category that patients may become unduly alarmed about the potential outcome of hospitalization and delay or avoid treatment all together. For example, a patient having ophthalmologic disease will see a HCFA predicted mortality rate of up to 80 percent.

...While HCFA states that their data is not recommended to be used to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals, we believe this data will be considered by patients when selecting a hospital in which to receive treatment.

...Western Baptist Hospital finds it interesting that the 1986 study which is developed using approximately the same number of admissions and deaths as occurred in 1985 indicates the mortality for 1986 is at the exact midpoint of predicted mortality while the 1985 study singled out Western Baptist Hospital from other Kentucky hospitals as having a higher than predicted mortality rate. This would seem to suggest flaws in the methodology used in one year or the other.

Again, we thank the Health Care Financing Administration for an opportunity to comment on the mortality study and we hope our comments will be helpful in avoiding misinterpretation of the study results.

Sincerely,

H. E. Feezor

nmc

the salvation army
BOOTH
memorial HOSPITAL

7380 Turfway Road, Florence, Kentucky 41042 (606) 525-5200

...Tomorrow's Care
with Yesterday's Comfort

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Adminisration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Rates - Provider Number 180045

Dear Dr. Roper:

Following are our comments relative to the mortality rate information supplied by HCFA.

The data used by HCFA indicates that a total of 146 medicare patients admitted to Booth Memorial Hospital died within 30 days of admission. Of these, 120 died while still a patient of the hospital while 26 (17.9%) died after discharge. Our own records indicate that 2,145 medicare admissions occured in 1986; while HFCA information indicated 1,304 admissions occured. Presumably, this discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of medicare patients treated at Booth Memorial Hospital is correct. Our own records also indicate that of the 120 medicare patients who died within 30 days of admission while still an inpatient, none where still alive at the time of discharge. It is impossible to determine the percentage of the 26 patients dying after discharge who were in fact alive, as information concerning death ater discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

We also note that in all of the diagnostic categories the hospital's actual mortality rate falls within the range of the predicted mortality rate.

I trust that these comments will be helpful to you.

Sincerely,

Ronald Lyons, Major
Administrator

Louisiana

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease								
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
ABBEVILLE GENERAL HOSP ABBEVILLE LA 70510	LA-13	731	11	8-15	36	36	14-45	16	44	12-55	18	6	3-38	32	31	11-40	18	39	21-64	32	22	9-40	55	24	14-38						
ABRAM KAPLAN MEM HOSP KAPLAN LA 70548	LA-14 *	329	13	7-16	14	43	10-55	7	0	6-65	5	0	2-68	24	38	10-44	8	63	10-69	3	33	2-82	42	17	9-34						
ACADIA-ST LANDRY PARISH HO CHURCH POINT LA 70525	LA-15 *	94	23	8-24	8	88	12-72	4	50	4-77	.	.		1	100	0-97	2	100	3-91	2	50	1-89	12	33	8-55						
ALLEN PARISH HOSPITAL KINDER LA 70648	LA-16	187	10	9-21	7	0	4-63	13	15	11-58	7	29	1-58	15	27	9-52	10	10	18-73	8	13	4-60	17	12	8-47						
AMERICAN LEGION HOSPITAL CROWLEY LA 70526	LA-17 *	604	14	10-18	37	41	18-49	21	38	15-54	10	20	3-51	59	24	14-36	25	44	22-60	8	0	2-57	40	20	11-37						
AMI RIVERVIEW MEDICAL CENT GONZALES LA 70737	LA-18	126	13	8-22	4	75	4-77	4	25	5-79	9	11	2-52	10	10	5-55	6	67	9-74	3	0	1-81	18	22	7-45						
AMI ST JUDE MEDICAL CENTER KENNER LA 70065	LA-19	643	11	8-16	44	18	13-41	22	32	14-52	11	18	5-53	37	11	12-40	21	48	21-61	17	6	6-45	48	13	10-33						
ASCENSION GENERAL HOSPITAL GONZALES LA 70707	LA-20 *	237	11	8-18	10	50	4-54	6	33	7-71	6	17	0-66	17	24	7-46	7	43	14-77	12	17	6-54	28	7	5-32						
ASSUMPTION GENERAL HOSPITA NAPOLEONVILLE LA 70390	LA-21 *	153	12	7-19	3	33	3-84	4	75	3-76	4	50	5-78	8	13	5-60	10	20	14-68	3	33	1-81	17	29	6-45						
BATON ROUGE GEN MEDICAL CT BATON ROUGE LA 70821	LA-22	3685	12	9-15	317	27	20-35	140	24	20-36	72	14	8-28	213	22	17-30	111	43	30-50	59	20	8-31	270	24	14-26						
BEAUREGARD MEMORIAL HOSPIT DE RIDDER LA 70634	LA-23	784	13	10-17	19	63	16-57	34	29	15-46	22	9	5-39	36	22	11-39	28	46	26-62	15	7	5-47	172	17	12-26						
BIENVILLE GENERAL HOSPITAL ARCADIA LA 71001	LA-24	253	15	9-20	8	63	9-68	15	47	10-53	6	0	1-63	19	21	8-45	6	50	13-80	25	12	6-39	43	12	8-32						
BOGALUSA COMMUNITY MEDICAL BOGALUSA LA 70427	LA-25	763	12	9-17	25	48	20-58	27	33	18-53	9	22	3-55	41	32	14-41	26	38	23-60	24	13	11-47	61	16	11-33						
BONNABEL HOSPITAL METAIRIE LA 70005	LA-26 *	399	18	13-22	13	31	11-59	17	29	14-56	6	33	2-63	43	30	12-38	16	63	24-70	12	33	6-53	45	20	14-40						
BOSSIER MEDICAL CENTER BOSSIER CITY LA 71111	LA-27	1011	10	8-15	68	22	17-40	29	24	13-46	18	11	6-44	58	31	14-36	22	45	25-65	22	18	7-43	71	21	11-31						
BUNKIE GEN HOSP BUNKIE LA 71322	LA-28	447	14	8-17	17	41	11-53	14	43	11-56	6	33	3-65	35	40	11-38	9	56	17-74	22	23	10-47	57	14	9-30						
BYRD MEMORIAL HOSP LEESVILLE LA 71446	LA-29 *	524	9	8-17	11	36	9-60	28	21	15-48	13	8	2-43	20	20	9-45	16	31	19-64	8	13	2-57	90	8	11-29						
CALOWELL MEMORIAL HOSP COLUMBIA LA 71418	LA-30	326	6	8-18	5	40	9-79	16	19	11-54	7	0	2-59	16	0	7-48	8	50	19-79	5	0	2-68	56	4	10-32						
CATAHOULA PARISH HOSP JONESVILLE LA 71343	LA-31 *	152	18	9-22	4	50	9-84	6	50	10-76	1	0	0-100	11	55	9-58	3	67	6-86	8	38	2-56	28	18	9-40						
CHALMETTE GEN HOSP CHALMETTE LA 70043	LA-32 *	853	12	8-15	42	19	12-40	28	36	15-49	27	15	6-37	46	20	15-41	32	41	23-56	19	37	6-43	92	21	11-29						
CHARITY HOSP OF NEW ORLEAN NEW ORLEANS LA 70140	LA-33	1327	14	7-14	166	25	17-34	47	36	14-39	11	27	2-48	57	26	11-33	33	33	23-57	47	26	6-30	68	29	8-28						
CITIZENS MEDICAL CENTER COLUMBIA LA 71418	LA-34	271	10	8-18	7	43	15-79	3	0	3-82	1	100	2-98	12	8	11-60	5	40	9-79	5	40	5-74	28	18	11-42						
OAUTERIVE HOSP INC NEW IBERIA LA 70560	LA-35	817	8	7-15	69	16	14-37	21	24	12-50	23	22	6-39	35	14	12-40	27	37	22-58	10	40	8-61	58	5	8-29						
OE LA RONOE HOSP INC CHALMETTE LA 70043	LA-36	703	14	8-16	25	48	15-52	23	35	14-50	12	25	8-55	45	31	12-37	23	43	19-58	27	19	8-42	55	18	10-32						
OEQUINCY MEMORIAL HOSPITAL DE QUINCY LA 70633	LA-37 *	235	10	7-18	11	55	8-59	13	23	11-59	2	0	0-90	14	36	5-47	2	50	2-90	3	0	0-82	33	15	10-38						
DESOTO GEN HOSP MANSFIELD LA 71052	LA-38	442	14	9-18	25	40	17-54	18	50	12-52	5	0	3-71	27	33	13-46	13	46	19-68	17	41	8-49	49	16	10-33						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ABBEVILLE GENERAL HOSP ABBEVILLE LA 70510	4	25	8-84	4	0	15-91	17	18	1-34	6	0	0-100	138	4	2-10	51	6	1-18	5	0	0-100	37	0	1-18	37	0	0-25
ABRAM KAPLAN MEM HOSP KAPLAN LA 70548	4	0	1-76	1	0	0-97	8	0	0-56	.	.		64	2	1-14	29	10	2-26	3	0	0-100	12	0	0-44	9	11	0-98
ACADIA-ST LANDRY PARISH HO CHURCH POINT LA 70525	1	0	0-99	2	50	3-91	2	0	0-97				10	0	0-48	4	0	0-74	.			11	18	1-43	2	0	0-100
ALLEN PARISH HOSPITAL KINDER LA 70648	.	.		2	50	3-91					.		26	8	1-25	13	0	1-40	1	0	0-100	14	0	0-38	2	0	0-100
AMERICAN LEGION HOSPITAL CROWLEY LA 70526	13	54	8-58	10	40	12-67	8	13	1-53	3	0	0-100	84	5	2-13	24	0	3-30	9	0	0-100	43	0	1-17	14	7	0-58
AMI RIVERVIEW MEDICAL CENT GONZALES LA 70737	1	0	1-97	5	20	9-79	3	0	0-88	.			16	6	0-37	6	0	0-65	.	.		10	0	0-47	7	0	0-92
AMI ST JUDE MEDICAL CENTER KENNER LA 70065	11	27	8-61	5	0	6-75	11	9	1-44	3	0	0-100	65	14	2-15	16	0	1-35	4	0	0-100	107	4	2-10	28	4	0-28
ASCENSION GENERAL HOSPITAL GONZALES LA 70707	1	100	2-98	4	75	12-88	6	0	0-64	.	.		35	0	1-20	6	0	0-75	1	0	0-100	21	5	1-27	10	10	0-50
ASSUMPTION GENERAL HOSPITA NAPOLEONVILLE LA 70390	1	0	0-98	2	50	3-91	1	0	0-100				24	0	1-25	9	0	0-53	.	.		16	6	1-34	9	0	0-86
BATON ROUGE GEN MEDICAL CT BATON ROUGE LA 70821	26	19	9-47	40	43	23-56	92	14	5-18	28	0	0-47	440	4	3-8	168	5	1-11	5	0	0-100	405	5	3-7	220	2	0-5
BEAUREGARD MEMORIAL HOSPIT DE RIDDER LA 70634	13	15	8-58	5	40	7-76	13	8	3-45	2	0	0-100	82	4	1-12	39	10	2-22	6	0	0-97	59	3	1-14	35	0	0-20
BIENVILLE GENERAL HOSPITAL ARCADIA LA 71001	3	33	4-86	7	57	14-77	1	0	0-100				21	0	1-28	3	0	0-97	2	0	0-100	16	13	0-34	5	0	0-96
BOGALUSA COMMUNITY MEDICAL BOGALUSA LA 70427	10	60	12-69	5	40	10-81	3	0	0-93	2	0	0-100	114	4	2-12	25	4	1-26	1	0	0-100	98	5	2-11	39	0	0-17
BONNABEL HOSPITAL METAIRIE LA 70005	12	67	13-66	16	31	21-67	12	8	2-43	4	0	0-97	37	[illegible]	2-22	32	6	3-27	2	0	0-100	14	0	0-37	13	0	0-63
BOSSIER MEDICAL CENTER BOSSIER CITY LA 71111	15	13	7-54	8	25	7-65	27	4	2-28	14	0	0-98	125	5	2-11	53	0	1-17	15	0	0-78	85	7	1-12	83	0	0-9
BUNKIE GEN HOSP BUNKIE LA 71322	1	0	0-97	6	67	13-80	2	0	0-96				59	3	1-14	26	8	3-29	5	0	0-71	34	9	1-21	16	0	0-42
BYRD MEMORIAL HOSP LEESVILLE LA 71446	5	20	5-75	14	36	20-69	5	0	0-70				48	0	1-15	36	3	1-21	2	0	0-100	63	6	1-14	33	6	0-31
CALDWELL MEMORIAL HOSP COLUMBIA LA 71418	12	17	9-60		.		1	0	0-98	.			46	2	1-16	9	11	0-51	5	0	0-100	16	0	0-35	10	0	0-65
CATAHOULA PARISH HOSP JONESVILLE LA 71343	3	33	6-87	2	0	6-95	1	0	0-100		.		15	0	0-36	8	0	0-56	.			12	8	0-42	5	0	0-100
CHALMETTE GEN HOSP CHALMETTE LA 70043	7	0	0-65	5	20	9-80	17	24	1-34	5	0	0-100	110	4	2-11	40	10	1-20	2	0	0-100	84	2	1-12	67	0	0-12
CHARITY HOSP OF NEW ORLEAN NEW ORLEANS LA 70140	23	22	4-43	9	22	9-66	20	25	1-31	34	0	0-56	80	4	2-13	97	6	1-13	18	6	1-31	66	8	1-12	60	0	0-14
CITIZENS MEDICAL CENTER COLUMBIA LA 71418	3	0	2-83	6	100	20-87							39	3	1-18	21	0	1-30	2	0	0-100	33	3	1-21	6	0	0-96
DAUTERIVE HOSP INC NEW IBERIA LA 70560	6	0	3-68	3	100	7-88	18	11	1-33	3	0	0-100	133	4	2-11	50	0	1-17	10	0	0-100	54	4	1-14	38	0	0-21
DE LA RONDE HOSP INC CHALMETTE LA 70043	6	33	5-71	12	50	15-66	15	7	2-38				69	4	2-15	29	7	2-25	6	0	0-97	79	1	1-12	51	0	0-17
DEQUINCY MEMORIAL HOSPITAL DE QUINCY LA 70633	3	0	4-85	1	0	1-97	1	0	0-100				26	0	2-26	19	5	2-33	1	0	0-100	19	5	0-30	14	0	0-54
DESOTO GEN HOSP MANSFIELD LA 71052	10	10	7-61	5	40	7-77	9	33	1-50				53	0	1-16	32	0	1-22	3	0	0-100	36	8	2-20	18	0	0-41

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
OIXON MEMORIAL HOSPITAL OENHAM SPRINGS LA 70726	LA-39	439	13	8-17	16	44	10-53	10	10	8-59	8	13	6-62	18	17	10-49	12	67	17-67	9	22	3-55	36	25	12-40						
DOCTORS HOSP OF OPELOUSAS OPELOUSAS LA 70570	LA-40	636	12	8-15	40	43	15-45	21	24	14-52	15	33	4-45	27	11	9-40	14	64	18-66	8	0	1-56	59	22	9-30						
DOCTORS HOSPITAL INC SHREVEPORT LA 71101	LA-41	830	8	5-12	40	23	13-42	17	29	13-55	8	13	3-57	37	11	11-38	15	53	19-66	11	9	5-53	42	29	8-33						
DOCTORS HOSPITAL OF JEFFER METAIRIE LA 70006	LA-42 *	613	6	5-13	71	20	18-41	10	0	7-58	6	17	3-65	20	30	9-45	4	50	8-83	4	25	1-75	23	17	5-36						
OR WALTER OLIN MOSS REGION LAKE CHARLES LA 70605	LA-43	237	11	6-16	6	33	4-67	4	50	3-76	3	0	0-84	20	10	8-44	8	38	9-67	11	18	3-50	28	7	6-34						
E A CONWAY MEMORIAL HOSPIT MONROE LA 71210	LA-44 *	531	13	7-15	30	47	14-46	15	0	9-52	13	15	8-54	21	14	10-46	19	68	20-62	21	38	4-38	60	18	9-30						
E JEFFERSON GENERAL HOSP METAIRIE LA 70011	LA-45	3457	11	8-15	270	31	21-36	122	20	19-36	39	21	6-32	167	20	16-29	165	33	29-46	68	15	9-31	219	17	12-25						
E S PIKE MEM HOSP KENTWOOD LA 70444	LA-46 *	240	14	10-20	2	50	2-90	6	50	6-70	2	0	0-92	13	23	10-56	10	20	12-66	19	11	9-48	38	24	11-39						
EARL K LONG MEMORIAL HOSPI BATON ROUGE LA 70805	LA-47	309	19	9-18	22	18	13-51	12	17	10-58	6	17	2-64	22	23	9-43	21	57	18-57	15	40	7-49	36	25	7-33						
EYE EAR NOSE AND THROAT HO NEW ORLEANS LA 70112	LA-48 *	225	1	0-14	4	0	3-76	.	.	.	.	.	.	1	0	0-97	.	.	.	1	0	0-99	1	0	0-100						
FAIRVIEW HOSP BAYOU VISTA LA 70380	LA-49 *	140	19	9-22	10	60	10-64	5	20	7-76	2	50	0-91	4	50	3-76	8	50	13-72	1	0	0-99	15	27	7-49						
FRANKLIN FOUNOATION HOSP FRANKLIN LA 70538	LA-50	381	13	9-19	20	35	10-48	10	50	9-62	8	0	3-57	40	13	10-35	11	36	19-73	20	20	6-43	46	20	12-37						
FRANKLIN PARISH HOSP WINNSBORO LA 71295	LA-51	532	13	10-18	20	25	9-47	26	23	15-49	14	14	6-49	37	11	13-40	17	59	20-64	35	11	6-35	65	18	12-34						
GARY MEMORIAL HOSPITAL BREAUX BRIDGE LA 70517	LA-52 *	185	11	7-18	7	43	6-67	3	0	2-82	4	0	0-76	8	13	4-59	1	100	2-98	4	50	2-75	36	19	9-36						
GLENWOOD REGIONAL MED CENT WEST MONROE LA 71291	LA-53	1437	11	9-15	109	36	22-43	51	29	17-42	27	15	5-35	74	20	14-34	32	53	24-57	10	0	3-51	167	14	12-26						
GUEYOAN MEMORIAL HOSP GUEYOAN LA 70542	LA-54 *	96	6	3-16	3	33	1-81	1	100	1-97	2	50	0-92	3	0	1-81	.	.	.	2	0	0-90	12	0	4-49						
HAMILTON MEDICAL CENTER HO LAFAYETTE LA 70506	LA-55 *	664	11	7-15	62	31	16-41	17	47	10-51	18	11	6-43	23	22	9-43	11	36	16-68	7	29	2-60	64	20	10-31						
HAROTNER MEDICAL CENTER OLLA LA 71465	LA-56	306	3	7-16	12	17	12-62	8	25	14-74	8	0	4-59	17	6	10-50	4	25	8-83	2	0	0-94	45	4	8-32						
HCA NORTH MONROE HOSPITAL MONROE LA 71203	LA-57	869	11	10-18	71	24	21-45	14	14	14-60	18	22	11-52	44	25	12-38	27	41	25-62	16	6	6-46	111	15	13-29						
HIGHLAND HOSP SHREVEPORT LA 71101	LA-58	925	14	9-16	106	27	16-36	23	39	14-50	28	29	8-39	28	29	11-43	36	50	23-55	20	10	5-42	84	26	14-33						
HIGHLAND PARK HOSPITAL COVINGTON LA 70433	LA-59	448	9	7-15	12	17	8-56	7	14	6-65	10	0	3-51	22	23	10-45	13	46	19-69	10	10	4-54	47	19	11-35						
HOMER MEM HOSP HOMER LA 71040	LA-60 *	406	11	8-16	12	58	16-68	.	.	.	8	13	4-59	17	24	11-51	9	33	13-70	11	18	4-52	64	13	10-30						
HOOD MEM HOSP AMITE LA 70422	LA-61	324	13	9-19	6	67	9-75	9	67	11-66	1	100	0-97	29	17	11-41	11	9	17-70	11	0	4-51	59	19	10-31						
HOTEL DIEU HOSP NEW ORLEANS LA 70112	LA-62	2091	12	7-14	174	26	14-31	73	38	19-41	41	22	8-33	124	23	16-32	54	37	25-52	30	17	6-36	104	19	13-31						
HUEY P LONG CHARITY HOSP PINEVILLE LA 71360	LA-63 *	292	16	6-15	23	43	13-50	9	44	6-59	11	0	2-47	5	0	4-71	4	0	9-84	10	30	1-50	31	23	7-34						
HUMANA HOSP OAKDALE OAKDALE LA 71463	LA-64	412	15	9-18	13	62	15-65	10	30	7-57	5	0	1-68	27	37	11-42	9	78	15-72	12	17	4-51	73	16	13-33						

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
DIXON MEMORIAL HOSPITAL OENHAM SPRINGS LA 70726	9	33	5-62	5	60	9-79	8	0	1-54				39	8	1-18	37	3	3-24	.			43	2	2-18	14	0	0-48
OOCTORS HOSP OF OPELOUSAS OPELOUSAS LA 70570	10	40	6-60	17	35	17-62	12	0	1-42	12	0	0-99	60	3	1-14	42	10	1-20	10	0	0-98	36	0	1-19	58	0	0-14
DOCTORS HOSPITAL INC SHREVEPORT LA 71101	5	40	2-71	10	50	17-73	28	4	2-25	50	0	0-25	85	4	1-11	58	2	1-16	9	0	0-98	63	5	2-15	124	0	0-7
OOCTORS HOSPITAL OF JEFFER METAIRIE LA 70006	3	0	1-82	4	50	8-83	6	0	1-62	11	0	0-89	62	*2	1-14	66	2	0-15	4	0	0-100	33	3	0-19	64	0	0-13
OR WALTER OLIN MOSS REGION LAKE CHARLES LA 70605	2	50	2-90	6	50	12-79	3	0	0-90	1	0	0-100	25	8	1-25	9	33	0-54	3	0	0-100	16	6	0-36	5	0	0-97
E A CONWAY MEMORIAL HOSPIT MONROE LA 71210	7	29	7-69	2	100	5-93	7	14	0-59	26	0	0-81	31	10	1-21	31	6	1-23	4	0	0-100	35	3	1-18	18	6	0-64
E JEFFERSON GENERAL HOSP METAIRIE LA 70011	25	36	10-50	21	48	21-63	87	10	3-16	96	0	0-9	382	3	3-9	169	4	2-11	12	0	0-100	366	5	3-7	187	2	0-5
E S PIKE MEM HOSP KENTWOOD LA 70444	6	67	7-74	5	60	8-78	1	0	0-99	.	.		25	4	2-26	12	0	1-43				28	4	1-22	7	0	0-98
EARL K LONG MEMORIAL HOSPI BATON ROUGE LA 70805	3	33	0-90	1	100	1-97	7	0	0-59	.	.		21	0	0-28	13	8	0-42	4	0	0-100	32	9	1-20	7	0	0-58
EYE EAR NOSE AND THROAT HO NEW ORLEANS LA 70112	.	.		.	.			.		172	0	0-6	.	.		.	.		.	.		2	0	0-100		.	
FAIRVIEW HOSP BAYOU VISTA LA 70380	2	50	6-95	5	40	10-81	1	0	0-99		.		6	17	0-68	10	10	0-55	.	.		7	0	0-70	1	0	0-100
FRANKLIN FOUNDATION HOSP FRANKLIN LA 70538	13	15	10-61	6	50	11-77	5	20	0-78	.	.		49	10	1-17	25	4	1-26	2	0	0-100	27	0	1-23	19	0	0-74
FRANKLIN PARISH HOSP WINNSBORO LA 71295	12	8	5-54	10	40	14-69	5	0	0-68	.			67	7	1-14	44	2	1-18	2	0	0-100	61	2	2-14	7	0	0-94
GARY MEMORIAL HOSPITAL BREAUX BRIDGE LA 70517	5	60	5-75	.	.		2	0	0-92				20	0	1-29	11	0	1-44	2	0	0-100	11	9	0-47	8	0	0-95
GLENWOOD REGIONAL MED CENT WEST MONROE LA 71291	13	15	8-58	14	43	19-69	24	13	2-28	26	0	0-85	166	5	2-9	68	6	2-16	10	0	0-100	125	2	2-9	97	3	0-8
GUEYDAN MEMORIAL HOSP GUEYDAN LA 70542	1	0	0-97	.	.		.	.		1	0	0-100	16	0	0-35	2	0	0-98	1	0	0-100	12	25	1-41	2	0	0-100
HAMILTON MEDICAL CENTER HO LAFAYETTE LA 70506	9	22	2-57	10	20	17-73	13	0	1-40	4	0	0-100	90	2	2-12	50	0	0-17	6	0	0-100	51	2	1-15	45	4	0-15
HAROTNER MEDICAL CENTER OLLA LA 71465	4	0	5-80	2	0	6-94	1	0	0-99	.	.		40	0	1-17	23	4	1-27	2	0	0-100	26	4	1-23	17	0	0-41
HCA NORTH MONROE HOSPITAL MONROE LA 71203	20	10	3-43	15	40	17-65	9	33	1-50	7	0	0-100	77	3	2-14	55	2	1-17	12	0	0-99	81	4	2-13	50	0	0-13
HIGHLAND HOSP SHREVEPORT LA 71101	8	25	4-62	8	50	14-75	38	5	2-22	7	0	0-91	117	4	1-10	56	5	1-17	5	0	0-100	50	6	1-16	87	3	0-9
HIGHLAND PARK HOSPITAL COVINGTON LA 70433	4	25	3-77	3	0	3-84	9	22	1-50	1	0	0-100	60	2	1-14	25	0	1-26	10	0	0-95	59	0	1-14	19	0	0-52
HOMER MEM HOSP HOMER LA 71040	6	33	7-73	2	0	5-94	1	0	0-100	.	.		59	7	2-17	10	0	0-48				36	3	1-19	20	10	0-32
HOOD MEM HOSP AMITE LA 70422	5	20	2-71	5	20	8-78	2	50	0-95	.	.		37	11	2-21	15	7	1-36	1	0	0-100	32	0	1-20	9	11	0-82
HOTEL DIEU HOSP NEW ORLEANS LA 70112	52	23	4-35	24	46	18-57	39	8	2-22	148	1	0-6	144	4	2-10	95	6	2-14	15	0	0-98	180	4	2-9	165	1	0-6
HUEY P LONG CHARITY HOSP PINEVILLE LA 71360	3	0	2-82	2	100	1-89	8	0	0-55	3	0	0-100	27	15	1-25	22	5	1-28	4	0	0-100	14	7	0-41	18	11	0-33
HUMANA HOSP OAKDALE OAKDALE LA 71463	3	33	3-84	5	40	12-83	.	.		1	0	0-100	55	4	1-15	23	0	2-29	1	0	0-100	33	12	1-20	15	0	0-45

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HUMANA HOSP OF WINN PARISH WINNFIELD LA 71483	LA-65	456	13	9-17	9	44	6-60	15	27	12-56	16	0	2-40	22	41	11-47	17	53	21-65	21	19	8-45	80	10	10-29
HUMANA HOSP-MARKSVILLE MARKSVILLE LA 71351	LA-66	362	12	9-19	15	40	15-62	20	25	13-52	14	14	4-46	25	8	11-45	13	31	14-62	18	6	3-40	45	27	10-35
HUMANA HOSPITAL LAKE CHARL LAKE CHARLES LA 70605	LA-67 *	11	0	1-44	3	0	2-81	.	.		.	.		.	.		.	.		.	.		1	0	0-98
HUMANA HOSPITAL NEW ORLEAN NEW ORLEANS LA 70128	LA-68	54	6	3-21	5	20	2-69	3	33	4-85	1	0	0-100	.	.		.	.		.	.		4	0	3-76
HUMANA HOSPITAL SPRINGHILL SPRINGHILL LA 71075	LA-69	570	13	10-18	19	37	18-61	18	50	14-55	17	6	5-42	36	36	10-37	32	50	27-60	8	0	3-57	62	5	7-27
HUMANA HOSPITAL VILLE PLAT VILLE PLATTE LA 70586	LA-70	508	9	8-16	16	38	11-55	17	18	11-52	4	0	0-76	49	20	12-36	13	54	17-66	15	7	4-44	61	15	10-31
IBERIA GENERAL HOSP AND ME NEW IBERIA LA 70560	LA-71	797	12	8-15	48	23	13-40	29	45	17-51	22	23	8-43	45	29	13-38	20	40	16-56	22	23	9-45	62	18	11-33
JACKSON PARISH HOSPITAL JONESBORO LA 71251	LA-72 *	327	20	11-20	9	67	9-65	19	32	15-55	2	0	2-90	23	26	7-40	21	86	24-65	14	7	3-45	66	21	12-34
JENNINGS AMERICAN LEGION H JENNINGS LA 70546	LA-73	543	15	9-17	20	35	11-50	21	43	11-48	15	7	5-47	37	19	11-38	25	40	24-62	11	36	3-51	90	26	12-30
JO ELLEN SMITH MEMORIAL HO NEW ORLEANS LA 70114	LA-74	1217	10	9-16	65	17	17-41	99	13	18-37	24	21	6-38	78	23	16-36	36	36	25-57	26	23	7-40	52	17	9-32
L S HUCKABAY MEMORIAL HOSP COUSHATTA LA 71019	LA-75 *	645	10	8-15	23	39	17-55	16	38	13-57	15	13	5-46	56	18	11-33	14	79	22-71	17	6	5-43	55	18	9-31
LADY OF THE SEA GENERAL HO GALLIANO LA 70354	LA-76	261	15	8-17	10	40	11-65	8	13	6-62	3	33	0-85	22	18	9-43	12	42	16-66	5	60	3-71	35	37	8-35
LAFAYETTE GENERAL MEDICAL LAFAYETTE LA 70505	LA-77	1774	9	7-14	95	19	17-38	52	35	18-44	20	5	4-37	87	28	16-35	51	39	26-53	18	0	3-39	83	11	10-28
LAKE CHARLES MEM HOSPITAL LAKE CHARLES LA 70601	LA-78 *	1655	10	7-13	95	23	14-34	51	33	15-40	26	15	5-35	66	23	13-34	38	47	24-55	27	15	5-36	146	20	12-28
LAKESIDE HOSP METAIRIE LA 70001	LA-79	151	2	2-13	12	8	5-51	1	0	0-97	1	0	1-97	2	0	1-89	1	100	2-98	1	0	1-97	8	0	2-56
LAKEWOOD HOSPITAL MORGAN CITY LA 70381	LA-80 *	512	13	8-16	22	55	15-54	14	71	14-61	7	43	4-63	35	9	11-39	17	35	18-61	24	25	5-38	45	13	9-32
LALLIE KEMP CHARITY HOSP INDEPENDENCE LA 70443	LA-81	259	11	7-16	12	8	9-57	6	0	3-65	4	0	0-77	13	31	9-54	13	38	15-64	8	0	2-56	36	14	6-31
LANE MEMORIAL HOSP ZACHARY LA 70791	LA-82	805	13	8-15	34	38	13-44	24	29	13-48	7	0	0-60	40	23	13-40	29	52	23-58	20	30	8-46	92	22	11-29
LASALLE GENERAL HOSP JENA LA 71342	LA-83 *	420	12	9-18	8	63	10-69	17	35	13-55	6	50	1-63	52	13	12-35	9	33	16-74	32	9	5-33	65	12	9-29
LEESVILLE GENERAL HOSP LEESVILLE LA 71446	LA-84 *	118	8	9-24	2	0	3-91	2	0	1-89	3	0	0-83	4	25	5-79	5	80	13-83	2	0	0-90	33	6	12-42
LINCOLN GENERAL HOSP RUSTON LA 71270	LA-85	1582	13	8-15	105	36	19-39	62	31	18-41	25	24	4-35	74	19	14-34	48	48	27-55	17	18	4-42	124	25	13-30
LOUISIANA STATE UNIVERSITY SHREVEPORT LA 71130	LA-86	1935	16	9-16	147	28	19-37	80	34	18-39	29	28	6-36	66	20	14-34	42	31	24-53	71	28	11-33	132	30	13-29
MADISON PARISH HOSP TALLULAH LA 71282	LA-87 *	276	17	11-21	6	83	13-80	14	29	9-54	11	18	4-51	13	31	8-53	22	64	24-64	5	40	5-73	37	14	10-36
MEADOWCREST HOSPITAL GRETNA LA 70056	LA-88 *	744	12	8-16	35	26	15-47	20	40	12-50	8	38	2-56	40	13	14-42	27	48	23-59	16	19	5-45	63	21	11-33
MEDICAL CENTER OF BATON RO BATON ROUGE LA 70816	LA-89 *	466	8	7-16	42	14	11-38	15	27	14-59	11	18	7-57	20	20	8-44	13	31	17-66	2	0	3-91	28	29	7-37
MERCY HOSPITAL OF NEW ORLE NEW ORLEANS LA 70119	LA-90	1918	11	8-15	166	27	18-36	52	35	15-40	54	19	8-30	121	26	15-31	58	28	26-52	36	19	10-40	113	19	12-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HUMANA HOSP OF WINN PARISH WINNFIELD LA 71483	10	30	4-58	5	60	14-85				1	0	0-100	41	5	1-17	23	4	2-30	5	0	0-100	31	3	1-21	12	0	0-64
HUMANA HOSP-MARKSVILLE MARKSVILLE LA 71351	5	60	7-78	2	100	6-94	7	14	1-57				56	2	1-14	16	6	2-36	4	0	0-100	28	0	1-22	10	0	0-66
HUMANA HOSPITAL LAKE CHARL LAKE CHARLES LA 70605																			4	0	0-100						
HUMANA HOSPITAL NEW ORLEAN NEW ORLEANS LA 70128				1	100	3-99	1	0	0-100				3	0	0-86	3	0	0-98	7	0	0-100	4	0	0-83	3	0	0-100 3
HUMANA HOSPITAL SPRINGHILL SPRINGHILL LA 71075	11	18	8-62	13	23	19-70	8	13	2-54				108	6	3-13	20	5	1-30	6	0	0-99	40	3	1-17	32	0	0-23
HUMANA HOSPITAL VILLE PLAT VILLE PLATTE LA 70586	5	20	3-72	9	22	15-73	8	0	1-53				84	2	1-12	11	0	0-45	1	0	0-100	35	6	1-19	27	4	0-36
IBERIA GENERAL HOSP AND ME NEW IBERIA LA 70560	5	0	4-74	12	42	13-64	17	6	1-34	3	0	0-100	109	1	1-10	29	10	1-24	10	0	0-100	57	4	1-14	49	0	0-17
JACKSON PARISH HOSPITAL JONESBORO LA 71251	5	20	1-71	1	0	0-97							33	0	1-20	13	23	1-40	3	0	0-100	31	16	1-21	7	0	0-100
JENNINGS AMERICAN LEGION H JENNINGS LA 70546	6	17	3-68	3	33	4-85	1	100	0-99				80	6	1-12	10	10	1-47	6	0	0-99	57	4	1-14	18	0	0-71
JD ELLEN SMITH MEMORIAL HO NEW ORLEANS LA 70114	8	13	7-67	13	23	14-63	55	5	2-19	3	0	0-100	99	4	2-12	58	7	2-17	7	0	0-96	104	5	2-12	77	3	0-10
L S HUCKABAY MEMORIAL HOSP ODUSHATTA LA 71019	7	0	4-65	2	50	3-91	8	13	1-53				63	5	1-13	38	3	1-20	2	0	0-100	58	5	1-15	27	0	0-33
LADY OF THE SEA GENERAL HO GALLIANO LA 70354	5	40	5-75	1	0	0-97	5	20	0-70				32	0	1-20	15	7	0-40	2	0	0-100	22	5	1-26	5	0	0-98
LAFAYETTE GENERAL MEDICAL LAFAYETTE LA 70505	20	35	14-58	14	43	16-64	19	0	2-33	48	0	0-21	125	5	2-12	92	3	1-13	19	0	0-98	336	5	2-7	112	0	0-7
LAKE CHARLES MEM HOSPITAL LAKE CHARLES LA 70601	14	29	8-56	20	30	17-59	47	15	3-22	13	0	0-100	181	3	1-8	102	4	1-12	7	0	0-100	74	3	1-12	187	1	0-5
LAKESIDE HOSP METAIRIE LA 70001	1	0	1-97							21	0	0-70	23	0	0-26	3	0	0-99	11	0	0-100	10	0	0-55	14	0	0-62
LAKEWOOD HOSPITAL MORGAN CITY LA 70381	6	50	5-70	3	100	9-90	12	17	0-43				59	2	1-15	27	0	0-25	8	0	0-100	45	4	1-16	22	0	0-61
LALLIE KEMP CHARITY HOSP INDEPENDENCE LA 70443	6	17	1-66	2	100	9-97	2	0	0-95				25	12	0-24	8	0	0-55				52	4	1-15	2	0	0-100
LANE MEMORIAL HOSP ZACHARY LA 70791	6	50	3-68	16	38	16-62	26	12	2-28	6	0	0-100	108	4	2-11	54	15	2-19	4	0	0-100	56	0	1-14	47	0	0-18
LASALLE GENERAL HOSP JENA LA 71342	4	0	3-78	10	40	10-64	1	0	0-97				46	2	1-16	18	11	3-35	2	0	0-100	47	4	1-16	14	0	0-73
LEESVILLE GENERAL HOSP LEESVILLE LA 71446	1	0	0-99	4	50	10-86							11	0	0-50	5	0	0-75				14	0	0-39	1	0	0-100
LINCOLN GENERAL HOSP RUSTON LA 71270	6	33	8-74	8	50	11-70	44	11	3-22	11	0	0-99	187	6	2-10	87	10	1-14	9	0	0-95	166	3	3-10	96	0	0-8
LOUISIANA STATE UNIVERSITY SHREVEPORT LA 71130	55	18	6-37	41	63	23-56	49	12	3-21	23	0	0-90	144	13	3-12	112	13	3-15	11	9	0-84	165	10	3-11	41	2	0-16
MADISON PARISH HOSP TALLULAH LA 71282	2	0	0-94	7	43	11-74	1	0	0-100				24	0	1-26	19	0	3-35	1	0	0-100	36	17	2-21	4	0	0-100
MEADOWCREST HOSPITAL GRETNA LA 70056	10	30	10-66	13	31	15-65	19	5	1-31	11	0	0-99	85	6	2-12	43	14	2-20	10	0	0-99	51	8	1-16	31	0	0-25
MEDICAL CENTER OF BATON RO BATON ROUGE LA 70816	3	67	8-90	3	67	7-88	14	7	2-41	6	0	0-98	40	0	1-17	30	0	1-24	3	0	0-100	52	4	1-15	52	0	0-13
MERCY HOSPITAL OF NEW ORLE NEW ORLEANS LA 70119	16	13	6-50	12	50	16-68	47	6	4-23	17	6	0-90	218	5	3-10	109	5	1-13	18	0	0-50	186	3	2-9	140	0	1-7

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	Comment/ Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
MERRYVILLE GENERAL HOSP MERRYVILLE LA 70653	LA-91 *	105	12	7-21	1	0	0-99	3	33	3-83	1	0	0-98	8	25	5-59	6	67	14-80				16	6	4-42						
MINDEN MEDICAL CENTER INC MINDEN LA 71055	LA-92	617	14	9-17	25	32	14-50	25	48	15-51	10	30	5-55	38	29	10-37	10	40	15-69	24	13	8-42	80	21	13-32						
MONTELEPRE MEMORIAL HOSP NEW ORLEANS LA 70119	LA-93 *	238	9	4-14	12	33	4-48	7	14	8-68	2	0	1-89	9	33	5-58	4	75	6-81	5	0	1-69	12	25	5-49						
MOOSA MEMORIAL HOSP EUNICE LA 70535	LA-94	352	12	9-18	13	38	8-55	10	20	8-60	9	22	6-60	33	21	10-38	24	29	22-60	11	27	7-56	43	14	10-34						
MOREHOUSE GENERAL HOSP BASTROP LA 71220	LA-95 *	982	12	9-16	61	26	15-40	36	42	16-45	27	11	6-36	60	20	14-37	22	41	22-61	24	13	9-44	102	19	13-30						
NATCHITOCHES PARISH HOSPIT NATCHITOCHES LA 71457	LA-96 *	530	15	9-17	17	47	15-58	21	33	14-52	7	29	6-67	30	23	10-40	13	38	15-64	23	17	6-40	89	21	12-30						
NEW ORLEANS GENERAL HOSPIT NEW ORLEANS LA 70130	LA-97 *	306	12	6-15	13	31	8-54	7	43	6-66	9	22	3-54	31	10	9-37	2	50	5-93	6	0	1-63	22	5	4-35						
NORTH CADDO MEM HOSP VIVIAN LA 71082	LA-98	372	11	9-18	18	50	13-54	12	17	11-60	2	50	0-89	20	20	12-51	8	100	21-81	14	14	7-51	59	12	9-30						
NORTH CLAIBORNE HOSPITAL HAYNESVILLE LA 71038	LA-99	198	16	10-22	7	43	11-73	6	33	9-74	7	0	1-59	12	17	6-52	9	67	19-76	5	20	1-68	36	22	11-38						
NORTHSHORE REGIONAL MEDICA SLIDELL LA 70461	LA-100	741	12	8-15	35	34	14-44	16	25	12-55	13	8	5-50	43	16	12-38	18	39	20-63	18	39	5-43	72	26	11-30						
OPELOUSAS GENERAL HOSPITAL OPELOUSAS LA 70570	LA-101*	969	11	8-15	56	23	14-39	19	32	11-49	27	19	7-38	57	21	13-35	19	32	17-58	20	35	14-54	101	17	12-29						
OSCHSNER FOUNDATION HOSP NEW ORLEANS LA 70121	LA-102	3605	10	8-14	342	20	19-34	71	28	18-39	76	16	12-33	141	18	16-30	118	40	29-48	40	15	11-40	203	21	13-26						
OUR LADY OF LOURDES HOSPIT LAFAYETTE LA 70501	LA-103	2538	9	7-14	177	19	16-32	51	16	17-42	42	19	8-33	98	28	15-33	70	31	25-48	38	24	9-37	180	24	16-30						
OUR LADY OF LOUROES ST MAR ST MARTINVILLE LA 70582	LA-104*	90	19	8-23	2	100	2-90	2	50	3-91	2	0	1-89	7	43	3-61	2	50	5-93	3	0	5-85	19	37	8-45						
OUR LADY OF THE LAKE REGID BATON ROUGE LA 70809	LA-105	4724	10	8-14	406	23	21-36	138	28	20-37	89	17	9-28	183	26	17-31	142	38	29-47	62	18	10-34	237	23	15-29						
PENDLETON MEMORIAL METHODI NEW ORLEANS LA 70127	LA-106	1463	13	9-16	137	28	19-38	41	39	16-44	33	15	8-36	98	24	13-30	45	44	23-52	18	22	5-42	100	21	14-32						
PHYSICIANS AND SURGEONS HO SHREVEPORT LA 71101	LA-107*	917	8	7-14	73	19	12-34	53	13	16-40	15	13	7-50	33	24	11-39	18	33	16-58	14	14	3-44	59	19	10-32						
PLAQUEMINES PARISH GEN HOS PORT SULPHUR LA 70083	LA-108*	112	13	8-23	2	50	0-90	2	50	4-93	4	25	1-74	8	0	7-63	7	86	20-83	6	33	3-65	13	15	7-52						
PLEASANT HILL GEN HOSP PLEASANT HILL LA 71065	LA-109*	141	15	10-24	5	80	10-80	6	17	8-73	1	0	0-98	6	17	4-67	5	60	7-77	3	0	1-82	35	9	11-39						
POINTE COUPEE GEN HOSP NEW ROADS LA 70760	LA-110	406	19	12-21	20	45	16-57	17	29	16-59	9	56	5-59	42	26	12-38	21	57	25-66	23	9	6-40	61	21	11-33						
PREVOST MEMORIAL HOSP DONALDSONVILLE LA 70346	LA-111*	196	17	9-20	2	100	3-91	7	43	9-70	5	0	1-68	20	35	11-48	3	33	5-86	8	25	5-61	21	19	9-45						
RAPIDES GENERAL HOSP ALEXANDRIA LA 71301	LA-112	2730	11	8-15	211	27	19-35	82	24	17-38	51	12	7-30	152	22	15-29	86	42	29-51	44	14	7-33	228	18	14-27						
RAYNE-BRANCH HOSP RAYNE LA 70578	LA-113	376	12	6-14	8	38	4-59	10	10	6-56	9	11	4-55	24	25	9-41	8	50	14-74	20	25	4-39	24	4	5-36						
REGENT HOSP FELICIANA MED CLINTON LA 70722	LA-114*	272	10	9-19	3	0	2-82	7	57	8-69	12	0	4-49	14	7	7-50	21	29	21-62	10	0	3-51	26	4	6-36						
REGENT HOSPITAL ACADIANA I ERATH LA 70533	LA-115*	186	20	10-22	6	50	4-68	3	33	2-82	7	43	7-68	15	27	7-48	4	50	9-85	7	29	7-67	27	37	10-42						
REGENT HOSPITAL EAST CARRO LAKE PROVIDENCE LA 71254	LA-116*	205	17	8-19	4	75	6-80	17	41	12-54	2	0	0-93	14	7	6-48	6	67	16-83	4	0	1-74	26	19	8-39						

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
MERRYVILLE GENERAL HOSP MERRYVILLE LA 70653	1	0	2-98	1	0	0-97	.	.	.	.	.	.	10	0	0-49	7	0	1-57				10	0	0-48	2	50	0-98			
MINDEN MEDICAL CENTER INC MINDEN LA 71055	11	27	7-59	16	50	20-67	21	10	2-32	.	.	.	75	5	1-13	49	6	2-19	7	0	0-100	45	0	1-17	7	0	0-92			
MONTELEPRE MEMORIAL HOSP NEW ORLEANS LA 70119	4	25	2-76	1	100	1-97	9	22	0-54	.	.	.	30	0	1-21	22	0	1-28	3	0	0-100	16	13	0-34	24	0	0-47			
MOOSA MEMORIAL HOSP EUNICE LA 70535	4	0	1-76	3	67	6-87	3	33	1-81	5	20	0-100	55	4	1-15	3	0	0-83	6	17	0-100	17	0	0-33	15	0	0-60			
MOREHOUSE GENERAL HOSP BASTROP LA 71220	18	50	9-53	2	0	2-90	23	9	3-32	1	0	0-100	137	4	3-12	81	4	1-13	8	0	0-99	62	5	1-14	41	0	0-18			
NATCHITOCHES PARISH HOSPIT NATCHITOCHES LA 71457	11	45	11-65	1	100	1-97	20	0	2-32	2	0	0-100	64	9	2-15	24	0	0-27	1	0	0-100	37	11	1-19	24	4	0-34			
NEW ORLEANS GENERAL HOSPIT NEW ORLEANS LA 70130	5	40	2-71	4	50	8-84	1	0	0-100	5	0	0-99	28	11	1-23	8	13	0-54	2	0	0-100	31	0	0-20	14	7	0-81			
NORTH CADDO MEM HOSP VIVIAN LA 71082	5	20	2-71	5	60	13-84	2	0	0-92	.	.	.	44	0	1-17	16	0	0-36	3	0	0-93	52	2	1-15	13	0	0-73			
NORTH CLAIBORNE HOSPITAL HAYNESVILLE LA 71038	3	33	4-85	9	44	14-71	1	0	0-99	.	.	.	28	0	2-24	8	0	0-58	2	0	0-100	12	8	0-45	6	0	0-93			
NORTHSHORE REGIONAL MEDICA SLIDELL LA 70461	7	29	5-66	8	63	15-76	21	14	2-31	2	0	0-100	91	2	1-12	44	0	2-20	4	0	0-97	101	3	2-11	48	2	0-17			
OPELOUSAS GENERAL HOSPITAL OPELOUSAS LA 70570	17	12	13-59	8	63	12-73	15	7	2-38	16	0	0-79	112	4	1-10	86	10	1-13	11	0	0-99	51	10	1-16	45	0	0-15			
OSCHSNER FOUNDATION HOSP NEW ORLEANS LA 70121	53	9	4-35	34	44	27-62	54	4	4-21	93	0	0-8	285	3	3-9	175	1	1-11	31	0	0-55	438	9	3-7	221	1	0-5			
OUR LADY OF LOURDES HOSPIT LAFAYETTE LA 70501	15	13	10-58	6	0	11-77	40	8	3-24	42	0	0-33	321	4	3-9	129	5	1-12	7	0	0-100	273	5	3-8	234	1	0-5			
OUR LADY OF LOURDES ST MAR ST MARTINVILLE LA 70582	.			.			.						14	0	1-37	1	100	2-98				10	20	1-46	3	0	0-100			
OUR LADY OF THE LAKE REGIO BATON ROUGE LA 70809	34	15	8-44	35	51	23-57	115	7	5-17	117	1	0-7	459	4	3-8	352	3	2-9	13	0	0-75	452	5	3-7	309	2	0-4			
PENDLETON MEMORIAL METHODI NEW ORLEANS LA 70127	20	20	12-55	17	24	17-62	38	8	2-23	2	0	0-100	139	5	2-10	116	4	2-13	6	0	0-95	105	4	1-10	144	2	0-6			
PHYSICIANS AND SURGEONS HO SHREVEPORT LA 71101	5	20	6-76	3	67	6-88	23	9	1-28	25	0	0-82	130	2	2-10	40	0	0-20	7	0	0-99	42	5	1-18	80	0	0-9			
PLAQUEMINES PARISH GEN HOS PORT SULPHUR LA 70083	.	.		1	0	0-97	.	.		.	.		13	0	0-47	2	50	0-91	.	.		16	0	0-34	1	0	0-100			
PLEASANT HILL GEN HOSP PLEASANT HILL LA 71065	2	100	6-95	3	33	4-84	.	.		.	.		8	13	0-54	8	0	2-54	.			16	13	1-33	3	0	0-100			
POINTE COUPEE GEN HOSP NEW ROADS LA 70760	6	50	13-81	6	67	9-74		.		1	0	0-100	40	8	1-19	16	13	1-36	2	0	0-100	22	5	1-26	6	0	0-98			
PREVOST MEMORIAL HOSP DONALDSONVILLE LA 70346	2	50	0-90	6	83	14-81		.		1	0	0-100	28	4	1-23	8	13	1-53	.	.		14	7	0-37	3	0	0-100			
RAPIDES GENERAL HOSP ALEXANDRIA LA 71301	23	17	14-55	32	34	20-55	80	9	4-18	8	0	0-100	336	6	3-9	141	3	2-13	37	0	0-54	235	3	2-8	193	1	0-5			
RAYNE-BRANCH HOSP RAYNE LA 70578	3	33	1-82	2	50	3-91	12	0	1-42	2	0	0-100	49	4	1-16	11	18	0-45	2	0	0-100	17	0	0-33	31	6	0-22			
REGENT HOSP FELICIANA MED CLINTON LA 70722	2	50	1-90	7	43	13-76		.		.			34	9	1-21	13	0	0-40	2	0	0-100	20	5	1-29	1	0	0-100			
REGENT HOSPITAL ACADIANA I ERATH LA 70533	4	75	10-87	3	100	8-90	4	0	1-74	.	.	.	30	10	3-26	10	0	1-47	3	0	0-100	4	25	0-78	4	0	0-100			
REGENT HOSPITAL EAST CARRO LAKE PROVIDENCE LA 71254	4	75	3-78	1	100	0-97	.						39	5	1-18	2	0	1-89	.			18	6	1-31	6	0	0-96			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RICHLAND PARISH HOSP RAYVI RAYVILLE LA 71269	LA-117	835	14	9-17	55	27	20-47	26	23	15-49	18	33	8-48	41	17	11-37	20	40	21-62	15	7	4-45	115	20	14-31
RICHLAND PARISH HOSPITAL-O DELHI LA 71232	LA-118	334	14	9-18	19	37	14-55	11	36	11-62	4	0	1-74	23	13	9-43	16	38	18-64	14	50	7-51	32	25	9-37
RIVER PARISHES HOSPITAL LAPLACE LA 70068	LA-119	499	12	8-16	25	24	10-44	21	29	12-50	14	14	4-45	41	17	11-36	24	33	20-58	14	21	6-49	38	18	7-32
RIVER WEST MEDICAL CENTER PLAQUEMINE LA 70764	LA-120*	533	17	10-19	26	58	17-53	32	31	15-47	4	50	0-75	41	24	13-39	27	44	23-60	21	29	7-43	62	24	11-33
RIVERLAND MEDICAL CENTER FERRIDAY LA 71334	LA-121	403	16	9-18	12	75	17-68	21	24	12-50	15	13	3-43	28	18	9-40	6	50	9-75	25	8	4-35	43	30	9-34
RIVERSIDE COMMUNITY HOSPIT BOSSIER CITY LA 71112	LA-122	343	13	8-18	16	50	15-60	14	36	11-56	6	17	1-63	21	24	8-43	7	57	14-77	8	0	3-58	37	16	8-35
RIVERSIDE MEDICAL CENTER FRANKLINTON LA 70438	LA-123	490	11	9-17	19	47	17-59	14	43	13-59	12	8	4-50	35	29	12-41	16	44	21-67	14	7	5-47	67	13	10-30
SABINE MEDICAL CENTER MANY LA 71449	LA-124	370	15	11-21	7	57	10-73	24	29	14-49	9	33	2-53	33	30	11-40	16	50	24-69	12	17	6-53	76	12	13-33
SAVOY MEDICAL CENTER MAMOU LA 70554	LA-125	875	9	7-14	47	40	16-44	27	33	14-48	24	21	7-40	50	24	11-34	12	33	13-63	14	0	6-50	81	11	9-27
SCHUMPERT MEDICAL CENTER SHREVEPORT LA 71101	LA-126	4544	10	7-14	361	23	20-34	112	29	20-38	76	13	9-29	156	29	16-30	122	36	28-47	63	14	8-30	278	16	15-28
SEVENTH WARD GENERAL HOSP HAMMOND LA 70404	LA-127*	1333	12	9-16	58	21	15-40	50	32	18-43	25	24	7-40	88	28	15-34	45	44	28-57	17	29	13-56	96	21	11-28
SLIDELL GEN HOSP SLIDELL LA 70458	LA-128	951	10	8-15	44	25	15-43	23	26	13-49	15	27	5-46	46	22	13-38	31	39	21-55	22	23	8-43	83	18	11-30
SOUTH CAMERON MEMORIAL HOS CAMERON LA 70631	LA-129*	55	11	7-27	2	100	4-92	2	50	2-90	1	100	0-99	5	0	2-68	2	50	3-91	9	0	2-53	13	0	4-47
SOUTH LOUISIANA MEDICAL CE HOUMA LA 70360	LA-130*	726	16	7-15	42	36	12-40	24	46	12-46	19	42	7-44	37	27	11-38	22	36	21-60	12	50	7-55	71	23	7-26
SOUTHERN BAPTIST HOSPITAL NEW ORLEANS LA 70115	LA-131	2790	9	8-14	206	30	19-35	91	30	19-38	61	13	10-33	148	20	16-31	69	26	27-51	39	13	7-34	150	13	13-28
SOUTHPARK HOSPITAL SHREVEPORT LA 71118	LA-132	318	9	6-15	20	45	11-50	8	25	8-66	2	0	0-90	15	33	10-52	9	67	14-70	7	0	0-62	34	3	6-32
ST ANNE GENERAL HOSPITAL RACELAND LA 70394	LA-133	499	11	7-15	36	31	12-42	14	36	13-60	12	0	2-45	22	27	9-44	18	56	16-59	10	30	3-52	50	12	9-32
ST CHARLES GENERAL HOSPITA NEW ORLEANS LA 70115	LA-134	1087	9	8-15	35	31	15-46	29	34	16-50	21	5	3-36	82	18	14-33	33	18	24-58	34	18	10-40	78	13	13-33
ST CHARLES HOSP LULING LA 70070	LA-135*	337	10	11-21	17	29	17-61	8	13	10-58	8	25	2-55	23	9	11-45	16	38	22-68	7	0	3-62	38	13	11-38
ST FRANCES CABRINI HOSPITA ALEXANDRIA LA 71301	LA-136	1886	11	8-15	114	25	18-37	48	10	18-44	32	16	11-42	85	21	15-34	67	45	26-50	32	28	9-40	137	23	13-29
ST FRANCIS MEDICAL CENTER MONROE LA 71201	LA-137	2987	10	8-15	224	24	20-37	98	32	21-40	42	14	6-31	123	23	15-31	93	51	30-51	72	7	8-30	258	13	13-26
ST HELENA PARISH HOSP GREENSBURG LA 70441	LA-138	181	6	6-17	1	100	0-97	1	0	0-97				16	6	8-49	4	25	8-83	4	25	5-79	25	4	8-40
ST JAMES PARISH HOSPITAL LUTCHER LA 70071	LA-139*	122	20	12-27	10	20	15-70	7	57	9-70	6	33	3-65	12	8	6-52	10	30	16-70	4	25	3-76	12	42	9-56
ST LUKE GEN HOSP ARNAUDVILLE LA 70512	LA-140*	142	18	9-23	11	82	19-73	6	17	8-72	1	0	0-100	9	22	5-58	2	100	4-93	4	0	5-79	14	29	9-54
ST PATRICKS HOSPITAL OF LA LAKE CHARLES LA 70601	LA-141*	2196	11	9-15	194	31	22-39	74	28	19-40	27	26	8-40	101	23	15-33	67	33	25-49	41	24	7-34	164	17	13-27
ST TAMMANY PARISH HOSP COVINGTON LA 70433	LA-142*	1112	12	9-16	51	18	13-39	46	37	18-45	34	21	8-37	75	31	13-32	50	30	26-54	27	11	7-39	96	24	13-31

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
RICHLAND PARISH HOSP RAYVI RAYVILLE LA 71269	9	44	7-64	13	38	17-67	16	13	1-35	3	0	0-100	99	3	2-12	37	14	1-21	7	0	0-86	66	5	1-13	33	0	0-22			
RICHLAND PARISH HOSPITAL-D DELHI LA 71232	5	40	4-73	3	33	4-85	1	0	0-99	.	.		61	3	1-14	26	8	1-25	1	0	0-100	24	4	1-25	11	0	0-78			
RIVER PARISHES HOSPITAL LAPLACE LA 70068	8	25	7-67	5	20	6-75	12	17	2-43	6	0	0-100	54	2	1-16	18	6	0-47	4	0	0-100	39	3	1-17	21	0	0-57			
RIVER WEST MEDICAL CENTER PLAQUEMINE LA 70764	8	0	4-63	11	64	13-66	12	8	1-42				53	8	2-17	26	0	1-26	5	0	0-98	43	5	1-16	26	0	0-43			
RIVERLAND MEDICAL CENTER FERRIDAY LA 71334	14	36	11-60	9	56	14-71	6	17	0-63	1	0	0-100	45	4	1-16	16	6	1-36	3	0	0-100	26	12	1-23	17	0	0-60			
RIVERSIDE COMMUNITY HOSPIT BOSSIER CITY LA 71112	3	0	1-83	19	37	17-60	10	0	0-48				45	7	1-16	16	0	1-35				22	5	1-26	15	7	0-59			
RIVERSIDE MEDICAL CENTER FRANKLINTON LA 70438	6	17	2-66	4	50	6-81	3	0	0-84	6	0	0-100	41	10	1-19	19	5	2-33				54	0	2-16	16	0	0-43			
SABINE MEDICAL CENTER MANY LA 71449	12	8	6-57		.					1	0	0-100	47	4	1-17	11	0	1-44	2	0	0-100	27	11	1-23	5	0	0-96			
SAVOY MEDICAL CENTER MAMOU LA 70554	10	0	5-58	12	17	13-64	15	20	2-39	2	0	0-100	151	1	1-9	43	0	1-19	5	0	0-100	86	3	1-10	46	0	0-20			
SCHUMPERT MEDICAL CENTER SHREVEPORT LA 71101	40	18	9-43	19	58	21-65	98	8	4-16	55	0	0-27	539	5	3-8	207	4	2-11	53	0	0-50	424	8	3-7	351	2	0-4			
SEVENTH WARD GENERAL HOSP HAMMOND LA 70404	15	13	9-56	7	14	10-72	41	10	2-22	6	0	0-100	157	5	3-11	88	6	2-15	9	0	0-100	181	3	3-10	57	0	0-12			
SLIDELL GEN HOSP SLIDELL LA 70458	4	50	5-80	11	36	18-72	22	18	3-32	3	0	0-100	107	7	2-11	43	5	1-20	9	0	0-93	139	2	2-10	66	2	0-11			
SOUTH CAMERON MEMORIAL HOS CAMERON LA 70631		.		2	0	1-89					.		3	0	0-95	1	0	0-98	.			4	0	0-85	1	0	0-100			
SOUTH LOUISIANA MEDICAL CE HOUMA LA 70360	1	100	2-98	14	57	17-65	10	20	1-47	14	0	0-96	63	11	1-14	48	10	1-18	3	0	0-100	52	6	1-14	25	0	0-44			
SOUTHERN BAPTIST HOSPITAL NEW ORLEANS LA 70115	21	29	11-53	30	37	20-56	88	7	5-19	26	0	0-52	287	3	3-9	127	4	2-13	23	4	0-79	307	2	2-8	247	0	1-5			
SOUTHPARK HOSPITAL SHREVEPORT LA 71118	3	0	0-84	3	0	4-84	8	13	0-55				40	0	1-18	17	0	0-46	2	0	0-100	44	5	1-17	21	0	0-49			
ST ANNE GENERAL HOSPITAL RACELAND LA 70394	3	100	4-85	7	0	8-70	9	0	0-55	1	0	0-100	71	3	1-13	29	0	1-24	4	0	0-100	41	0	1-16	22	5	0-38			
ST CHARLES GENERAL HOSPITA NEW ORLEANS LA 70115	10	0	4-57	16	19	22-69	21	19	3-33	5	0	0-100	113	6	2-12	15	13	1-36	1	0	0-100	195	3	2-9	107	0	0-9			
ST CHARLES HOSP LULING LA 70070	7	43	7-69	8	38	18-79	6	0	1-62	1	0	0-100	23	4	1-27	8	0	0-56	1	0	0-100	49	2	2-17	17	0	0-44			
ST FRANCES CABRINI HOSPITA ALEXANDRIA LA 71301	13	15	6-54	13	38	17-68	32	13	2-24	9	0	0-100	241	4	2-9	107	4	1-12	23	0	0-94	222	5	2-8	96	0	0-8			
ST FRANCIS MEDICAL CENTER MONROE LA 71201	34	38	9-44	39	31	24-57	81	1	3-16	10	0	0-99	335	2	2-8	158	1	1-11	25	0	0-41	231	5	2-8	251	1	0-4			
ST HELENA PARISH HOSP GREENSBURG LA 70441	6	0	3-67	1	0	0-97							23	4	1-26	6	33	1-62				12	8	0-42	16	0	0-51			
ST JAMES PARISH HOSPITAL LUTCHER LA 70071	3	67	2-82	1	100	1-97	1	0	0-100				7	14	0-63							16	0	0-35	6	0	0-72			
ST LUKE GEN HOSP ARNAUDVILLE LA 70512	2	50	5-93				2	0	1-89				28	7	1-24	8	0	0-61	1	0	0-100	8	13	0-57	7	0	0-87			
ST PATRICKS HOSPITAL OF LA LAKE CHARLES LA 70601	21	14	10-52	27	44	21-59	47	13	4-23	6	0	0-100	218	4	3-10	135	3	1-11	12	0	0-77	209	4	2-9	127	2	0-7			
ST TAMMANY PARISH HOSP COVINGTON LA 70433	11	18	8-61	8	50	14-74	38	8	1-21				171	4	2-10	57	5	2-17	9	0	0-100	78	5	2-13	71	0	0-11			

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
STERLINGTON MEM HOSP STERLINGTON LA 71280	LA-143	309	20	11-21	7	57	4-63	9	56	10-66	5	20	1-68	17	35	9-49	4	100	15-90	21	5	5-40	56	34	14-37						
TENSAS MEM HOSP NEWELLTON LA 71357	LA-144*	178	16	10-22	4	75	6-80	8	25	10-68	2	0	1-89	22	23	10-46	7	86	16-79	17	0	7-47	23	22	9-44						
TERREBONNE GENERAL MEDICAL HOUMA LA 70360	LA-145*	1279	11	6-13	83	35	13-34	28	32	13-46	45	18	7-32	50	20	11-33	57	46	25-51	16	13	6-48	98	13	9-26						
THIBODAUX GENERAL HOSPITAL THIBODAUX LA 70301	LA-146	1050	11	7-14	84	20	13-34	35	40	18-48	22	18	5-39	45	29	13-38	33	33	20-53	16	31	8-51	76	20	9-28						
TOURO INFIRMARY NEW ORLEANS LA 70115	LA-147	3057	11	9-15	233	28	18-34	114	21	22-40	93	17	10-29	165	13	16-30	117	38	29-48	65	17	10-33	180	16	13-27						
TRI-WARD GENERAL HOSPITAL BERNICE LA 71222	LA-148*	194	17	10-22				6	17	9-75	7	14	3-61	5	40	2-69	6	33	10-76	14	29	10-57	36	22	14-44						
TULANE MEDICAL CTR HOSP NEW ORLEANS LA 70112	LA-149	1584	10	6-13	111	23	17-37	28	29	12-44	29	17	7-36	50	28	11-34	23	22	21-59	39	18	11-39	74	28	13-33						
UNION GENERAL HOSP FARMERVILLE LA 71241	LA-150	276	16	11-21	10	40	22-78	17	35	15-58	1	0	0-97	21	19	9-44	10	40	15-70	6	17	3-66	29	14	9-39						
UNITED MEDICAL CENTER NEW NEW ORLEANS LA 70117	LA-151*	558	13	8-16	27	30	10-44	18	33	11-51	17	12	3-39	40	20	10-36	23	61	21-59	15	7	3-44	35	14	8-36						
UNIVERSITY MEDICAL CENTER LAFAYETTE LA 70502	LA-152	413	15	6-14	23	39	16-54	10	40	8-60	2	50	0-90	15	20	6-46	12	42	11-60	13	31	5-49	34	15	5-29						
VA HOSP SHREVEPORT LA 71101	LA-153*	1	0	0-100																											
VILLA FELICIANA GERIATRIC JACKSON LA 70748	LA-154*	82	23	9-26				1	0	0-97	2	0	4-92	6	0	2-64	2	50	3-91	6	0	1-63	33	30	9-38						
W CALCASIEU CAMERON HOSP SULPHUR LA 70663	LA-155*	1059	13	8-15	61	34	17-42	31	35	15-46	28	25	5-35	50	26	11-34	40	43	24-54	19	26	8-47	112	17	10-26						
WASHINGTON-ST TAMMANY CHAR BOGALUSA LA 70427	LA-156	203	17	7-17	10	60	5-55	14	21	10-56	4	0	1-74	12	42	7-54	6	17	8-74	5	40	0-71	30	30	5-33						
WELSH GEN HOSP WELSH LA 70591	LA-157*	209	14	8-19	7	43	5-65	10	30	8-60	3	0	1-81	28	29	11-43	10	50	18-73	12	17	3-48	21	10	5-38						
WEST CARROLL PARISH HOSP OAK GROVE LA 71263	LA-158*	286	13	11-21	11	64	17-71	10	40	9-62	1	0	0-97	24	21	10-43	26	23	22-58	15	20	5-47	47	13	11-35						
WEST FELICIANA PARISH HOSP SAINT FRANCISVILLE LA 70775	LA-159	100	13	8-23	2	50	2-90	7	29	6-65	3	0	2-82	9	22	7-60	2	50	5-93	3	33	3-84	9	22	2-52						
WEST JEFFERSON MEDICAL CEN MARRERO LA 70072	LA-160	2202	12	9-16	167	29	18-35	69	29	18-40	27	19	4-34	130	25	17-33	99	44	29-49	49	29	11-37	132	11	12-27						
WESTPARK COMMUNITY HOSPITA HAMMOND LA 70403	LA-161	588	11	7-14	29	28	8-39	14	14	9-53	17	18	4-41	21	19	9-45	15	60	21-68	12	25	6-54	50	26	9-32						
WILLIS KNIGHTON MEDICAL CE SHREVEPORT LA 71103	LA-162	2616	10	7-14	165	26	20-38	72	17	18-39	54	24	7-30	129	27	17-32	92	45	26-48	32	16	6-36	132	10	12-27						
WOMANS HOSP BATON ROUGE LA 70815	LA-163	96	0	1-13	15	0	4-44																								
WOMENS AND CHILDRENS HOSPI LAFAYETTE LA 70508	LA-164*	25	0	0-34	1	0	0-97																								
WOODVIEW REGIONAL HOSPITAL PINEVILLE LA 71477	LA-165	194	9	7-17	7	43	5-65	4	0	4-77	3	0	1-81	18	11	10-50	3	100	4-85	15	13	4-44	29	3	5-33						

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
STERLINGTON MEM HOSP STERLINGTON LA 71280	6	17	5-70	10	60	14-69	1	0	0-100	.			11	0	0-48	67	6	4-21				19	0	1-29	3	0	0-97
TENSAS MEM HOSP NEWELLTON LA 71357	7	14	2-63	1	0	1-97	3	0	0-92	.	.		12	8	0-42	2	0	0-91	.			15	7	0-38	4	0	0-100
TERREBONNE GENERAL MEDICAL HOUMA LA 70360	4	75	2-77	6	33	8-74	18	0	1-32	6	0	0-100	120	6	2-11	70	1	1-14	15	0	0-100	180	7	1-8	98	1	0-9
THIBODAUX GENERAL HOSPITAL THIBODAUX LA 70301	15	27	7-53	7	43	10-72	23	0	1-28	22	0	0-96	136	4	2-10	132	2	1-11	12	0	0-99	79	9	2-12	56	4	0-15
TOURO INFIRMARY NEW ORLEANS LA 70115	29	17	9-46	39	31	23-56	58	5	3-19	58	0	0-18	249	3	3-9	133	3	2-12	28	0	0-80	317	6	3-8	177	3	0-6
TRI-WARD GENERAL HOSPITAL BERNICE LA 71222	3	67	6-87	1	100	2-98	1	0	0-100	.	.		25	4	1-25	14	0	4-43	.			31	16	2-23	4	0	0-99
TULANE MEDICAL CTR HOSP NEW ORLEANS LA 70112	22	14	3-42	17	35	14-58	23	17	2-29	99	0	0-9	102	9	3-13	56	7	2-18	10	0	0-79	158	7	2-10	137	1	0-6
UNION GENERAL HOSP FARMERVILLE LA 71241	7	57	10-74	6	67	12-79	.			.	.		35	6	1-19	16	13	5-43				35	3	1-19	3	0	0-100
UNITED MEDICAL CENTER NEW NEW ORLEANS LA 70117	13	31	8-57	4	0	9-84	3	33	0-83				52	4	1-16	23	13	2-29	2	0	0-100	67	4	1-13	17	6	0-49
UNIVERSITY MEDICAL CENTER LAFAYETTE LA 70502	6	17	3-67	4	100	9-85	13	15	2-41	11	0	0-100	41	12	1-17	13	31	1-40	2	0	0-100	33	6	0-19	21	5	0-63
VA HOSP SHREVEPORT LA 71101										.	.		.	.													
VILLA FELICIANA GERIATRIC JACKSON LA 70748				2	100	3-91				.	.		2	0	0-97	9	11	1-50									
W CALCASIEU CAMERON HOSP SULPHUR LA 70663	14	21	7-55	8	63	13-74	16	0	1-35	.	.		149	5	2-10	57	2	1-16	11	0	0-100	67	7	2-12	70	3	0-11
WASHINGTON-ST TAMMANY CHAR BOGALUSA LA 70427	4	25	1-76	2	50	4-92	.	.		.			18	11	0-32	6	0	0-68	1	0	0-100	18	6	0-31	2	0	0-100
WELSH GEN HOSP WELSH LA 70591	1	0	0-99	.			.			.	.		32	3	1-21	7	14	1-57	3	0	0-100	23	4	0-25	5	0	0-94
WEST CARROLL PARISH HOSP OAK GROVE LA 71263	5	0	2-71	2	50	2-90	1	0	0-99				18	0	0-32	12	8	1-42	1	0	0-100	35	3	1-19	13	0	0-49
WEST FELICIANA PARISH HOSP SAINT FRANCISVILLE LA 70775	3	0	2-82	3	67	8-90							8	25	0-63	9	0	1-50	1	0	0-100	11	0	0-44	.		
WEST JEFFERSON MEDICAL CEN MARRERO LA 70072	28	21	11-49	32	38	22-58	39	15	3-23	8	0	0-100	214	5	3-10	111	3	1-12	12	0	0-100	253	5	3-9	119	3	0-7
WESTPARK COMMUNITY HOSPITA HAMMOND LA 70403	11	18	6-58	4	50	10-86	8	13	0-59	2	50	0-100	82	6	3-15	24	0	0-27	8	0	0-100	66	3	1-12	40	0	0-26
WILLIS KNIGHTON MEDICAL CE SHREVEPORT LA 71103	13	23	10-60	13	15	13-63	49	4	2-20	94	0	0-13	246	2	2-8	177	3	2-11	22	5	0-85	323	7	3-8	168	1	0-6
WOMANS HOSP BATON ROUGE LA 70815	.									.									52	0	0-64	1	0	0-100	1	0	0-100
WOMENS AND CHILDRENS HOSPI LAFAYETTE LA 70508																1	0	0-100	13	0	0-100						
WOODVIEW REGIONAL HOSPITAL PINEVILLE LA 71477	1	100	1-97	1	0	0-97	2	0	0-92	2	0	0-100	17	0	0-34	12	8	1-42	1	0	0-100	14	7	0-37	7	0	0-89

*Written Comments Not Submitted

BOARD OF COMMISSIONERS
VERMILION PARISH HOSPITAL
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JAMES SEGURA III

Abbeville General Hospital

CHARLES W LANDRY PH D
CHIEF EXECUTIVE OFFICER

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Room 314-G Hubert Humphrey Building
200 Independence Avenue, Southwest
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to provide input on the mortality statistics for Abbeville General Hospital in 1986. Our hospital is a 97 bed, rural, acute care hospital providing such services as a twenty-four hour staffed Emergency Room, an eight bed Intensive Care Unit, General Medicine, General Surgery, Obstetrics, Pediatrics, and Orthopaedics.

The mortality data was reviewed by the Medical Record Director and the Utilization Review Coordinator. The statistics were checked very carefully against patient records and the following was noted. Of the eighty-two death cases, fourteen or 17.1% of the patients died after discharge from the hospital. One of the fourteen patients died at another hospital, and was therefore credited to Abbeville General Hospital in error. It should also be noted that this sample only represents the population of Medicare patients.

Our hospital Medical Staff committees monitor every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards. We have in place a concurrent Quality Assurance program whereby quality issues are addressed. The records of all patients who die at Abbeville General Hospital are reviewed monthly as part of our Quality Assurance program by the Quality Assurance Physician Advisor.

Again thank you for the opportunity to respond to the mortality data.

Sincerely,

Charles W. Landry

Charles W. Landry
Chief Executive Officer

CWL/wsb

118 NORTH HOSPITAL DRIVE • P.O. DRAWER 580 • ABBEVILLE, LA 70511-0580 • (318) 893-5466

ALLEN PARISH HOSPITAL

SERVICE DISTRICT NO. 3
Box 370
KINDER, LOUISIANA 70648

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COMMENTS ON THE HCFA MORTALITY DATA

Allen Parish Hospital, Kinder, Louisiana

Provider # 190133

Data Verification

The data used by HCFA indicate that a total of 18 Medicare patients admitted to Allen Parish Hospital in 1986 died within 30 days of admission. Of these, 13 died while still a patient of the hospital, while 5 died after discharge. Our own records indicate that of the reported 13 Medicare patients who died within 30 days of admission while still an inpatient, 1 was still alive at the time of discharge. The data used by HCFA also indicates that there were 187 Medicare admissions in 1986. Our own records indicate that 324 Medicare admissions occurred in 1986. The difference is due to HCFA using only the last Medicare admission of a patient who was admitted to the hospital more than one time during the year. We have no way of verifying whether the number of Medicare patients treated at Allen Parish Hospital according to this report is correct.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

Allen Parish Hospital's actual mortality rates fall well within or below the range of the predicted mortality rate. This indicates an acceptable mortality rate according to this report. However, we do not feel that this report should be used as indication of the hospital's acceptability as a "care giver". Many of the things that contribute to the patient dying are beyond any hospital's control. For example, the average age of the patients in this report who died is 74 years old. The normal expected outcome of many of these patients is death.

In addition to the above, these reports have nothing to do with the quality of care rendered to our patients. We have an ongoing inhouse quality review team that is constantly checking on the care that is being given in this hospital. We feel that the results of these checks are much more indicative of the quality of the hospital's services. An analysis of this nature performed by HCFA can do no more than identify potential areas for further evaluation, and as indicated, we are well within or below the acceptable ranges. Such data as this cannot be used directly as a measure of hospital performance.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

AMI Riverview Medical Center

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Medicare Provider Hospital #190207

Dear Dr. Roper:

Thank you for the opportunity to respond to the public release of data on hospital Medicare mortality rates for the period from January 1, 1986 to December 31, 1986.

AMI Riverview Medical Center is an acute care hospital operating in a growing community outside of Baton Rouge, Louisiana. Many of our patients are admitted to our facility with major medical and surgical illnesses. In addition to a general medical/surgical unit, we offer a combined intensive care, coronary care unit. Our medical staff includes over 125 physicians in fourteen medical specialties.

Review of mortality cases is carried out by medical staff committees as a part of on-going activities to assure that quality care is being delivered at our facility. Through our monitoring system we believe that we have a mechanism for feedback that aids us in continuing to meet and exceed quality care standards.

This release of Medicare mortality data for the fiscal year 1986 has afforded our medical staff and administration an additional opportunity to examine mortality statistics specific to Medicare patients treated at our hospital. Careful analysis of this data has shown that the overall rate of mortality for Medicare patients at AMI Riverview Medical Center fell within the range of predicted mortality as established by your agency.

Further analysis of the statistics for the individual diagnostic categories revealed that the only variation from the expected ranges was a lower than expected outcome for renal disease which can be attributed to the fact that only one case was identified as falling into this category during the time period reviewed.

We are proud to be delivering quality medical care to our community. We commend you on your efforts to focus on results which we believe will enable better quality of health care in our nation.

Sincerely,

Ward Boston III

Ward Boston III
Executive Director

WB:tb

1125 Highway 30 West Gonzales, Louisiana 70737 504 647 5000

AMI St. Jude Medical Center
180 W. Esplanade Avenue, Kenner, Louisiana 70065 (504) 468-8600

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

AMI St. Jude Medical Center is a 300 bed, general acute care hospital. It is located in the city of Kenner, Louisiana, a suburb of New Orleans. Having opened in September of 1985, the facility currently offers two intensive care units--surgical and cardiovascular--14 operating rooms, 24-hour lab, radiology E.R. and Respiratory Therapy. A complete fact sheet is attached for your review.

The Medical Staff at AMI St. Jude Medical Center conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the health care delivery system at this hospital. The Joint Commission on Accreditation of Hospitals bestowed on this facility its highest commendations for the AMI St. Jude Quality Assurance program and the excellent peer review process that is performed.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrators, President of the Medical Staff, Physician Chairman of Utilization Review and Quality Assurance and the Board of Directors. Our overall percentage of deaths is well below the national average.

As previously stated, review by this facility is always by individual case, and is conducted in an on-going fashion--not just when statistics such as the mortality data are released.

Thank you for the opportunity to present this response.

Sincerely,

John W. McDaniel
President and
Chief Executive Officer

Enclosure

cc: Debra Green
Jean Ann Hartzel
Ralieigh Hanbury
Beverly Glenn
Oliver Rogers

St. Jude Medical Center
180 W. Esplanade Avenue, Kenner, Louisiana 70065 (504) 468-8600

FACT SHEET

SERVICES

300 Beds including 42 Intermediate Care Beds with 40 Bed Telemetry Capability
2 Intensive Care Units (Surgical - 8 beds, Coronary - 8 beds, Cardiovascular - 4 beds)
14 Operating Rooms including: 2 Open Heart, 1 Opthalmology, 1 Cystoscopy, 1 Orthopedic, 1 Gynecology, 4 General Surgery, and 4 Outpatient Suites
24-Hour Emergency Center with Heliport
24-Hour Radiology Department (Areas include: Nuclear Medicine, CT Scanner, Ultrasound, Special Procedures, Digital Radiography)
24-Hour Laboratory Department (Areas include: Histology/Cytology, Blood Bank Services (without donor capability), Microbiology, Hematology, Chemistry, Immunology, Stat Lab Capabilities, Coagulation, Urinalysis)
24-hour Respiratory Therapy (Areas include: Ventilator Support, Stress Test, Echocardiography, Thallium Stress Test
EEG
EMG
Non-Invasive Vascular Lab
Cardiac Catherizatrion Lab
Rehabilitation Services including Physical Therapy, Speech Therapy and Occupation Therapy
Social Services
OB Services including:
- 4 LDR's (Labor, Delivery, Recovery, and Patient Rooms)
- 3 Conventional Labor Rooms
- 3 Delivery Suites
- 7 High Risk and Antempartum Rooms
- Fetal Monitoring Capability with Central Station
- Recovery Unit

Newborn Nursery - 14 beds
Intermediate Care - Level II, NICU - Level III - 9 Bed Capacity
Hospital Based Physicians
- Pathology -- Dr. Alvin J. Matthews
- Radiology -- Dr. Martin Belanger
- Anesthesiology -- Dr. Mack Thomas
- Emergency -- Selection in process
- Neonatology -- St. Juan J. Gershanik

Computerized Patient Care Information System (Intercare)
188,000 Square Foot Medical Office Building
Total Hospital Square Footage is 252,189
24 Bed Psychiatric Unit
Eating Disorders Unit
(as of 10/1/87)

THE GENERAL

BATON ROUGE GENERAL
MEDICAL CENTER
3600 Florida Boulevard
Post Office Box 2511
Baton Rouge, Louisiana 70821-2511
(504) 387-7000

October 26, 1987

Dr. William L. Roper
The Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

The Baton Rouge General Medical Center (The General) is appreciative of the opportunity to respond to the mortality data furnished to it by the Health Care Financing Administration (HCFA).

We feel that the data confirm the high quality of medical care delivered at The General. In every selected category, we are well within the range of predicted mortality rates as determined by HCFA.

We believe the following items may have contributed to these specific mortality rates and should be noted:

- Sepsis - 50% were transferred to our facility from nursing homes with an average age of 80. Of those, 37.5% died within two days of admission, indicating the severity of the illness prior to admission.

- Severe Trauma - 42% of the deaths in this category were a direct result of extensive burns. The General has achieved a national reputation for excellance in burn care and services Central, South and West Louisiana, it can be expected that a higher than average number of our trauma cases will be extensive burns.

- Pulmonary Disease - Pulmonologists have changed their practice patterns and are now placing the emphasis on outpatient management for those patients less acutely ill. This leaves only the more severe cases in the hospital. Mortality statistics will naturally be higher when considering only the most severe cases. If inpatient and outpatient numbers were combined, the percentage of deaths would be significantly smaller.

- Severe Acute Heart Disease - The high-tech, well-trained emergency medical service available in our area has made it possible for patients with little or no chance of survival to reach the hospital. Inevitable death, in these cases, is now attributed to the hospital which adversly impacts these mortality statistics.

- 23% of the deaths attributed to our hospital occurred after discharge and need further clarification as to their relevance for this study.

The General is a 360 bed acute care general medical-surgical hospital which accepts all patients for care, except obstetric. We are fully accredited by the Joint Commission on Accreditation of Healthcare Organizations. Our service area includes a major petro-chemical complex spread out along the Mississippi River.

The 600 members of our medical staff represent every medical and surgical specialty. We are a referral center with active programs of cardiology, open heart surgery, neurosurgery and oncology; we offer care for advanced kidney disease, major orthopedic problems, as well as pediatrics, plastic and reconstructive surgery, and general Medical/Surgical care. Our Emergency Department serves in excess of 31,000 patients annually, many of whom are critically ill or injured.

The medical staff of The General, with the support of hospital administration and the Board of Trustees, has for several years pursued an aggressive quality assurance program. This program monitors and evaluates significant indicators of quality of patient care, including deaths, so that each of the deaths occurring in our hospital has been reviewed for quality and appropriateness of medical care. Inpatients and outpatients are subject to this extensive review. Inpatient review begins at admission, continues at regular intervals throughout hospitalization, with final retrospective review after discharge.

The data furnished by HCFA have been carefully analyzed by our Medical Records Department, Quality and Resources Management Department, Medical Director of Quality Assurance and Utilization Review, and appropriate committees of the Medical Staff, with review by the Board of Trustees. We find the data furnished by HCFA to be in essential agreement, with minor exceptions, with our own statistics. Inasmuch as the data have had no adjustment for severity of illness, interpretation of the data may lead to conclusions unwarranted by fact. And as stated in your own letter that this "information on its own is not a complete measure of quality of care at an individual hospital", until HCFA develops additional statistical measures to deal with complex issues such as severity of illness, HCFA can not and should not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals.

Thank you for this opportunity to furnish input into the planned data release by HCFA on this very important information.

Sincerely,

Dan Borne'
Dan Borne'
Chairman, Board of Trustees

Edgar H. Silvey
Chief Executive Officer
and President

Gene Berry M.D.
B. Eugene ~~Berry, M.D.~~
Vice Chief of ~~Medical~~ Staff

October 12, 1987

PROVIDER NUMBER: 190050

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, Maryland 21207

The following comments are submitted in response to the upcoming release of HCFA Mortality Data:

Beauregard Memorial Hospital is a 102 bed rural not-for-profit hospital located in southwest Louisiana. Our active medical staff consists of 14 physcians. We are accredited by the Joint Commission on Accreditation of Healthcare Organizations. The nearest regional medical center is located 50 miles south of DeRidder.

Upon review of the statistics to be released concerning Beauregard Memorial Hospital, we determined that this listing included various errors. In review of our records, 8 of the 104 submitted deaths had inaccurate dates provided for this release. The listing is submitted in corrected format.

Another concern is the lack of access to the methodology used in generating actual and expected mortality rates for individual institutions.

The Medicare population served by Beauregard Memorial Hospital is less than 50% of the entire patient base. We do not feel that the statistics based solely on this high risk group are indicative of the quality of care we provide.

Eighteen percent of the total Medicare patients treated fall into the Cancer Diagnostic Category. Eighteen percent is a significant percentage of Medicare patients treated in our facility in light of our rural setting. It is in the Cancer Diagnostic Category that the hospital's actual mortality rate is 6% higher than the predicted mortality rate as determined by your methodology. This increase in mortality over your predicted range can be attributed to the fact that we are fortunate to have on our active medical staff an Oncologist. Therefore, patients in our referral area are able to receive treatment for this diagnostic category locally instead of being treated elsewhere.

P.O. Box 730
600 South Pine Street
DeRidder, Louisiana 70634-0730
(318) 462-0376 (318) 463-3566
VHA.
Affiliate of Voluntary Hospitals of America, Inc.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

I would like to receive a copy of HCFA's December Mortality Data Release.

Sincerely,

Theodore J. Badger, Jr.
Administrator

Bienville General Hospital

HOYE A. BOWMAN
Administrator

P. O. Drawer 599 • 810 Pine Street • Arcadia, Louisiana 71001 • Phone (318) 263-2044 Medicare Provider #190165

October 14, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: Comments on HCFA Mortality Data Release

Dear Dr. Roper:

Bienville General Hospital is a non-profit rural community hospital. We are a 30 bed facility which provides an acute level of care for all patients admitted for inpatient and/or outpatient services. Over half of our hospital admissions are Medicare patients with an average age of 77 years old.

The data used by HCFA indicates that a total of 37 Medicare patients admitted to our hospital during the calendar year of 1986 died within 30 days of admission. Of these, 26 died while still a patient in our hospital and 11 died after discharge from our hospital. Our own records indicate that 445 Medicare admissions occurred in 1986 at our hospital. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Our records also indicate that of the 37 Medicare patients who died within 30 days of admission while still an inpatient, 11 were still alive at the time of discharge. The average age for those Medicare patients figured in our mortality rate was 81 years old.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in this analysis.

Bienville General Hospital's "actual mortality rate" did not fall outside of the range of the "predicted mortality rate" in any of the diagnostic categories. One factor which is not taken into account is that 86% of the deaths for our hospital fell into a "high risk" category, i.e., cancer, cerebrovascular accidents, severe heart disease and pulmonary disease. In other words, 32 of the 37 deaths fell into a "high risk" category while only 2 of the deaths fell into a "low risk" category.

We would like to take this opportunity to reiterate that the mortality rate is determined by using a 30-day post-admission mortality rate rather than an inpatient mortality rate. Therefore those deaths which occurred after discharge but are included in HCFA's Mortality Rate could have resulted from management of the patient at home, in a post-acute facility or other undetermined conditions as information concerning death after discharge is not included in the patient's medical record.

In closing, Bienville General Hospital as well as the health care professionals which comprise our facility, have always and will continue to provide quality services and treatment to all patients served.

Sincerely,

Hoye A. Bowman

Hoye A. Bowman
Administrator

BOGALUSA
COMMUNITY
MEDICAL
CENTER

PROVIDER # 190095
October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

RE: MORTALITY STATISTICS
1986 Data Release

Dear Dr. Roper:

We appreciate this opportunity to respond to the recently received mortality data. The information has been processed through our Medical Records Director and our Medicare Review Coordinator and presented to our medical staff. Our records have been consistent with your findings with the exception of only a few cases.

Our hospital is well within the range and rates in all categories and we think it is important to monitor the statistics just as your office does. We are interested in insuring the quality of care of our patients at all times. Our medical staff participates on various committees within our hospital for the purpose of quality review control. Physicians, through peer review, can identify problems or potential problems so that appropriate action can be taken if necessary. Under the direction of the Quality Assurance Program, "Mortality Review" is an ongoing process to evaluate any death that occurs in our hospital.

Current "Joint Commission" standards require mortality review as part of their evaluation of hospital accreditation program, as well as many other identifiers of quality and appropriateness of care. Bogalusa Community Medical Center is accredited by the Joint Commission on Accreditation of Hospitals.

We are monitored by the Louisiana Health Care Review, Inc. (our peer review organization for this area) with "Generic Quality Screens." Our hospital has had NO physician to be identified as having a quality problem. We have an excellent record for Medicare admission approvals.

Established in 1950, as a community based-nonprofit hospital, we are a 98 bed acute care rural hospital that is growing and expanding to meet the needs of our community. Several new physicians have been added to our staff representing a variety of specialties. We have recently expanded our Emergency Department, Outpatient Department (now performs most advanced techniques in eye surgery in this area), Intensive/Coronary Care Units, and telemetry unit (cardiac monitoring). Other special services include an Addiction/Dependency Unit,

Skilled Nursing Facility, Home Health Care, Discharge Planning service, and a Social Service Department for establishing continuity of care post discharge. Patient teaching and employee training/development is a very important part of our Education Department. Every person who works at this hospital is vital and important in whatever role he/she plays in delivering the "Best" for our patients. We are a dedicated team that is proud to serve our community.

Once again, thank you for this opportunity to respond.

Sincerely,

Benjamin Light

Benjamin Light, Hospital Administrator
Bogalusa Community Medical Center

BOSSIER
MEDICAL CENTER

October 20, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to include our comments with the hospital specific mortality data being released by the Health Care Financing Administration.

The data has been verified, and, with only two minor exceptions, is judged to be correct. A special committee with five physician representatives was formed to study the cases and analyze the data. We are pleased that Bossier Medical Center's actual mortality rates fall well within the predicted ranges. The committee examined many of the categories in detail and noted in particular:

Low Risk Heart Disease:
* 67% of these patients had significant underlying conditions which complicated their illnesses (e.g. cancer or severe lung disease)
* 33% of these patients or their family members requested that no resuscitation efforts or heroic measures be taken
* the average age of the patients in this category was 83 years;

Severe Chronic Heart Disease:
* these patients had an average of three (3) other complicating conditions which impacted upon their chronic disease
* again, 33% of these patients or their family members requested that no resuscitation efforts or heroic measures be taken
* the average age of these patients was 80 years, with one patient being 102 years and another being 97 years old;

Severe Acute Heart Disease:
* 40% of these patients or their family members requested that no resuscitation efforts or heroic measures be taken
* 50% of these patients received respiratory and cardiac resuscitation efforts
* there was an average of 2.5 other underlying conditions or complications that affected the patients' overall disease state
* the average age of patients in this category was 79 years;

2105 AIRLINE DRIVE
BOSSIER CITY, LOUISIANA 71111
(318) 227-6000

Pulmonary Diseases:
* 36% of these patients were permanent residents of nursing homes
* there was an average of four (4) significant underlying conditions which complicated their illnesses (e.g. cancer, end-stage emphysema or past strokes)
* 36% of these patients or their family members requested that no resuscitation or heroic measures be taken.

The above comments illustate some general information about the types of patients and their multiple disease processes. We would like to stress that at Bossier Medical Center each patient is more than a statistic, and that each patient's medical management is tailored to fit the patient's needs. Whenever a patient expires, the medical record is carefully examined by the Medical Staff to study the management of the patient and the appropriateness of the care given. This is done as part of our on-going quality assurance program, and in an effort to continually identify opportunities to improve the quality of care rendered at Bossier Medical Center.

We would, as a final note, like to caution consumers that this data is not meant as a singular tool to measure a hospital's quality of care. The data does not reflect differences in procedures or, most importantly, severity of illness.

Sincerely,

David A. Bird
Executive Director

Thomas A. Edwards, M.D.
Chief of the Medical Staff

Paul A. Jordan, M.D.
Chairman, Special Committee
on HCFA Mortality Data

PJ/kj/hwt

Bunkie
General Hospital
Personalized Care and Concern

Ray A. Lemoine, Administrator

October 19, 1987

Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: Hospital Mortality Information

Dear Dr. Roper,

Thank you for the opportunity to respond to the release of data on hospital mortality rates for the year 1986.

The Director of Medical Records has validated that, with very minor exceptions, the data provided is accurate. The Medical Staff at Bunkie General Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the health care system at our hospital.

Again, thank you for the opportunity to present this reponse.

Sincerely,

Carl F. Jory, MD
Chairman of Board of Directors
Bunkie General Hospital

CFJ/ga

CALDWELL MEMORIAL HOSPITAL
P. O. BOX 899
410 MAIN STREET
COLUMBIA, LOUISIANA 71418
PHONE (318) 649-6111

October 21, 1987

Dr. William L. Roper
Health Care Financing Administration
Health Standard and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: HCFA Release of Mortality Data
Concerning Provider #190190

Dear Dr. Roper:

Thank you for the opportunity you have afforded us to respond to HCFA release of 1986 mortality data.

We are a 49 bed general acute care facility located in a rural community. We have in place an ongoing monitoring system which studies to improve the appropriateness and quality of care given by our medical staff and facility. This concern for our patients is reflected in our low death rate percentage published by HCFA.

A team involving the Director of Medical Records, a registered nurse, and the hospital administrator has reviewed HCFA's data and with few exceptions have found it to be reasonably accurate.

Fourteen of the eighteen deaths which occurred during the period involved patients greater than 78 years in age.

Unfortunately, our community is in a greater risk area for mortality due to our higher incidence of cancer, treatment of many elderly, diabetic patients, and economically depressed area. However, we will continue to monitor all deaths occurring in our facility in hopes of improving the quality of care given to every patient.

Again, thank you for the opportunity to respond to this data and have our comments appended to your release.

Sincerely,

Faye Long

Faye Long, Administrator

FL/sb

State of Louisiana
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF CHARITY HOSPITAL AT NEW ORLEANS
1532 TULANE AVENUE
NEW ORLEANS, LOUISIANA 70140
PHONE – 504/568-2311
LINC/621-2311

EDWIN W. EDWARDS
GOVERNOR

SANDRA L. ROBINSON, M.D., M.P.H.
SECRETARY

27 October 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration

RE: Charity Hospital Medicare Provider Number: 190005

Dear Dr. Roper:

We have verified the Medicare admissions to Charity Hospital in 1986 and found them to be accurate.

By carefully reviewing the records of those patients who expired, we reaffirmed that quality of care was appropriate. For those that died after discharge, a review of their medical records indicated that no patient was discharged prematurely, but that the patients were terminally ill and death was not unexpected.

One patient, [redacted], was incorrectly placed in the pulmonary disase category. When this patient's death is removed from this category, the actual mortality rate for pulmonary disease falls within the range of predicted mortality rates for Charity Hospital.

One patient included in the severe trauma category actually died of a myocardial infarction.

As an acute tertiary facility for the indigent, Charity Hospital receives many patients transferred from private facilities. Often our patients are desperately ill at the time of transfer. These factors have not been taken into account in the mortality statistics.

Sincerely,

James S. Storer, M.D.
Medical Director

Mr. Elliott C. Roberts, Sr.
Assistant Secretary

C M C

CITIZENS MEDICAL CENTER

P. O. BOX 1079 • HIGHWAY 165 S. • COLUMBIA, LA. 71418 • PHONE (318) 649-6106

October 26, 1987

Dear Mr. Roper:

Thank you for the opportunity to respond to the mortality statistics for calendar year 1986 prior to public disclosure. Our Administration and Medical Staff Leadership have reviewed the report and find that the majority of the data is accurate.

Citizens Medical Center is a 40 bed not-for-profit acute care facility. Our patient population is comprised of many people with serious medical and surgical illnesses. Our mission is to offer care to all people in need, with a large number of our patients being Medicare beneficiaries from the rural population we serve. We strive to offer an environment of hope, healing and peace to all who seek our care in times of illness.

The medical staff quality assurance program at Citizens Medical Center reviews all mortality cases for appropriateness of care. This medical staff peer review activity is an integral part of monitoring the health care delivery system at this hospital. The differences in mortality rates between hospitals should not be interpreted as differences in the quality of care. Our hospital plans to incorporate data from this report into our ongoing quality assurance and utilization management programs to improve ~~the~~ quality of care rendered.

Sincerely,

Mr. ~~Singleton~~, Administrator

HCA Dauterive Hospital

October 26, 1987

William R. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Mortality Statistics - 1986

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on Dauterive Hospital mortality rates for 1986. Since receiving the report, the Medical Records and Quality Assurance Departments have had an opportunity to review the data and compare it with medical staff findings. Each appropriate medical staff department reviews every mortality in our facility, on an on going basis for appropriateness of care.

Based on the comprehensive review of the data and the specific medical records it reflects, we are confident that you and any member of the public who requests a copy of our statistical information will be interested in our summary report.

The Quality Assurance Departmemt has validated, with some minor exceptions, the data received is accurate. HCFA's range of predicted mortality rates for all causes was 7 - 15%, and our overall rate was 8%. In each diagnostic category, Dauterive Hospital's rates fell well within the predicted ranges with the exception of the sepsis category.

The predicted percentage of deaths in this category was reported to be 7-88% and ours was 100%.
It should be noted that:

a) This represents 3 deaths in 1 year
b) Two of the three patients and/or families requested DO NOT RESUSCITATE status
c) All three patients had chronic and progressive end stage renal disease

PO Box 430
New Iberia Louisiana 70561-0430
Telephone (318) 365-7311
A subsidiary of HCA The Healthcare Company

The medical staff of Dauterive Hospital, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care rendered to the patient.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information has additional questions, please do not hesitate to call.

Sincerely,

Clay B. Hurley, Adm.

Clay B. Hurley
Administrator

CBH/dgc

DE LA RONDE HOSPITAL

October 2, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Mr. Roper:

As requested in your recent correspondence, attached you will find the information regarding mortality rates at our facility.

Please feel free to contact me if you require additional information.

Sincerely,

William E. Price

William E. Price
Managing Director

WEP:lby

attachments

9001 PATRICIA STREET • CHALMETTE, LOUISIANA 70043 • (504) 277-8011

A
UHS UNIVERSAL HEALTH SERVICES, INC
HOSPITAL

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

De La Ronde Hospital

DATE: October 1, 1987

TO: William E. Price
Managing Director

FROM: Brenda M. Boucher, RRA
Director, Medical Records B. Boucher

RE: HCFA death information

HCFA's letter of September 21, 1987, states that they must have received your comments concerning this information no later than October 28, 1987. That letter is returned to you along with this memorandum. Paragraph 3 of page 2 of that letter does contain other instructions concerning your comments to them.

De La Ronde Hospital's 1986 death list was compared to HCFA's list; this concerned Medicare patients only. Findings are listed below. Attached to this memorandum is supporting information.

A copy of HCFA's lists is attached (marked #1, 2 and 3). Unless specifically addressed below, HCFA's information contained on their lists is correct.

Those items highlighted in yellow contain incorrect death dates. Correct dates are as follows and the supporting information is attached:

3-27-86
12-30-86
10-26-86
8-22-86
1-7-87

Those items highlighted in blue are correct. Patients died after discharge at home, nursing home or other hospital, and the indicated dates were confirmed by physicians' office personnel.

Those items highlighted in pink were unable to be confirmed through the physicians' offices. However, physicians' office personnel did indicate that these patients have not been seen in their offices since the dates of discharge (or shortly thereafter) from this hospital.

Please advise if you require further information.

9001 PATRICIA STREET • CHALMETTE, LOUISIANA 70043 • (504) 277-8011

A
UHS Universal Health Services, Inc
Hospital
LA 36.1

DESOTO GENERAL HOSPITAL
207 JEFFERSON STREET / P. O. BOX 672
MANSFIELD, LOUISIANA 71052
(318) 872-4610

PRESIDENT
Robert R. Taylor

October 26,1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Medicare #: 190118

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for January 1, 1986 through December 31, 1986.

DeSoto General Hospital is a 69 bed general acute care facility, whose case mix includes many patients with major medical illnesses. We are a voluntary, nonprofit hospital whose services are motivated by and rendered in a spirit of cooperative effort. The services offered by the hospital include emergency care, critical care and home care.

The Quality Assurance Coordinator at DeSoto General Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Qualtiy Assurance program and peer review activities are an integral part of the monitoring of the health-care delivery system at this hospital.

The hospital specific mortality data reported by HCFA has been carefully reviewed and it was noted that all areas fell within the predicted mortality ranges established for this hospital. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

Again, thank you for the opportunity to present this response.

Sincerely,

Robert R. Taylor

Robert R. Taylor, President

Jack L. Grindle, M.D.

Jack L. Grindle, Chief of Staff

Dixon Memorial Hospital

10123 FLORIDA BLVD. • DENHAM SPRINGS, LOUISIANA 70726 • PHONE 665-8211

ADMINISTRATOR:
Lonnie Graeber

October 15, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for 1986 relative to Dixon Memorial Hospital. Since receiving this information, dated September 21, 1987, our staff has carefully reviewed the data and has validated its accuracy.

Dixon Memorial is a 52 bed general medical and surgical hospital serving the residents of Livingston Parish, Louisiana. Our active emergency department is staffed on a 24 hour basis by highly trained and experienced physicians and nurses. Both in and outpatient surgeries are performed by general surgeons, orthopedists, ophthalmologists, urologists, and other surgical specialists. The hospital provides an intensive/coronary care unit and a skilled nursing facility.

Mortality review of every patient who expires at this facility is performed by the physician staff and is an ongoing process of our Quality Assurance program. This peer review activity designed to insure the highest standard of care specifically focuses on the appropriateness and quality of medical management and overall care rendered in each case of death.

We would like to note that Dixon Memorial is within the range of predicted mortality rates for each diagnostic category. With regard to Severe Acute Heart Disease, six of the eight patients who expired averaged 89 years of age with a history of heart disease and multiple medical problems. The other two patients, although younger, had previous heart attacks, and after being stabilized, were transferred to other facilities where they later expired. The three patients who expired with Sepsis averaged 82 years of age and had other multiple medical problems.

Again, thank you for the opportunity to present this response.

Sincerely,

Lawrence C. Graeber
Administrator
Medicare Provider No. 190058

mlk

AMI Doctors' Hospital of Opelousas

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper,

In response to your letter regarding the publication of 1986 hospital mortality rates, the following comments are to be included with the publication of this data.

Doctors' Hospital of Opelousas is a general acute care hospital with 101 licensed beds, and is accredited by the Joint Commission on Accreditation of Hospitals (JCAH). As a JCAH accredited facility, there is ongoing review to assure the quality of care provided to all patients. As a part of reviewing the quality of care, all mortality cases are reviewed by active staff physicians.

The mortality data reported has been reviewed and validated by hospital personnel, with the conclusion that, although the data is accurate for the most part, the following points should be noted:

- 14% of the deaths reported occurred outside of the hospital after the patient(s) had been discharged;
- all of the mortality rates for Doctors' Hospital of Opelousas were within the expected ranges as determined by Medicare, and many were below the expected rate;
- the highest mortality rate for Doctors' Hospital was in the category of "Severe Acute Heart Disease," which is logically explained as follows:

  1. This is one of the highest risks of all categories; and
  2. 88% of the deaths in this category at Doctors' Hospital were due to acute myocardial infarction (severe heart attack). NOTE: The category of "Low Risk Heart Disease" had a 0% mortality rate at this hospital, despite the "expected" mortality rate of up to 19%.

Respectfully,

Brian L. Riddle
President/Chief Executive Officer

DOCTORS' HOSPITAL

1130 LOUISIANA AVENUE
SHREVEPORT LOUISIANA 71101
(318) 227-1211

October 14, 1987

Department of Health & Human Resources
Health Care Financing Administration
Washington, D.C. 20201

Dear Sir:

The HCFA hospital mortality data have been carefully reviewed and the following discrepancies identified:

1 - Two patients are listed which were never admitted to this hospital.

2 - One death is reported as being post-hospital but was actually an in-hospital death.

Information concerning a patient's death after discharge is not available as this is not included in the medical record.

Our records support the remaining information as submitted.

Yours truly,

Charles E. Boyd,
Administrator

CEB:jd

Enclosures (4)

A UHS hospital in partnership with physicians, serving the health care needs of our community

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

ATTACHMENT 5

DOCTORS' HOSPITAL
Shreveport, La. 71165-1526
Hospital ID Number 190115

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	7	2	7	2
CE -- Cerebrovascular Accidents	5	0	5	0
GC -- Gastrointestinal Catastrophes	1	0	1	0
GI -- Gastrointestinal Disease	2	1	2	1
GU -- Urologic Disease	0	1	0	1
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	2	1	2	1
HM -- Severe Chronic Heart Disease	1	3	1	2
HS -- Severe Acute Heart Disease	7	1	7	1
ME -- Metabolic/Electrolyte Disturbances	1	0	1	0
OP -- Orthopedic Disorders	0	0	0	0
PN -- Pulmonary Disease	11	1	11	1
RN -- Renal Disease	2	0	2	0
SE -- Sepsis	3	2	3	2
TR -- Severe Trauma	1	0	1	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	5	3	5	2
Total -- All Categories	48	15	48	13

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

State of Louisiana

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF HOSPITALS
DR. WALTER OLIN MOSS REGIONAL HOSPITAL
1000 WALTERS STREET, LAKE CHARLES, LOUISIANA 70605
(318) 477-3350 LINC 363-1011

EDWIN W. EDWARDS
GOVERNOR

SANDRA L. ROBINSON, M.D., M.P.H.
SECRETARY

MEDICARE PROVIDER NUMBER - 190161

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to provide our comments concerning selected mortality information about Medicare patients treated at Moss Regional Hospital in 1986. We ask that, if possible, our comments be included in the final publication of this data.

First, we want to commend the Health Care Financing Administration, HCFA, on its efforts to develop and perfect measures of health care quality. Many health care professionals believe that the growing concern over the cost of health care has been emphasized at the expense of quality. HCFA's efforts to monitor quality as well as costs are reassuring to those practicing health care providers who have always placed quality as the number one priority in the delivery of health care services.

At the same time that we applaud HCFA's efforts to develop and perfect measures of health care quality, we must voice our concern that HCFA's current public release of mortality data may be premature. Our major reservation concerning the public release of the HCFA data is that mortality rates, by themselves, do not measure quality. Mortality data are more appropriately used to identify or suggest areas for further review by health care professionals. We are concerned that raw mortality statistics may be misinterpreted and may cause confusion and apprehension among patients and the general public. We urge HCFA to work with health care providers, the Joint Commission on Accreditation of Hospitals, JCAH, and the academic community in developing indicators of quality health care that are more meaningful than simple mortality statistics and which express quality in terms of the beneficial effects of medical interventions and the health benefits derived in health care facilities.

Second, we wish to assure you and the public that Moss Regional Hospital places a very high value on the quality of health care

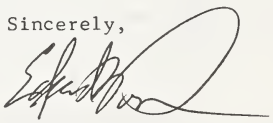
we provide. Moss Regional Hospital is fully accredited by the Joint Commission on Accreditation of Hospitals and maintains a comprehensive quality assurance program. In order to receive JCAH accreditation, hospitals and their medical staffs are required to provide effective mechanisms to monitor and evaluate the quality and appropriateness of patient care. JCAH accreditation is the public's assurance that such mechanisms are in place and fully functional at Moss Regional Hospital.

Physicians on our hospital medical staff meet monthly and monitor every death on an ongoing basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards. In addition to the ongoing review of deaths, the medical staff quality assurance program incorporates the ongoing monitoring of all major aspects of patient care for each major clinical service offered. It should also be noted that Moss Regional Hospital is a teaching hospital affiliated with the LSU School of Medicine in New Orleans. As such, special educational conferences are held for each major medical service. Our physicians are kept up-to-date on the state-of-the-art medical developments and issues pertinent to today's hospital environment.

Third, the HCFA mortality data for Moss Regional Hospital has been carefully reviewed by hospital administration, the hospital medical staff and the hospital Director of Quality Assurance. It should be noted that Moss Regional Hospital death rates for each of the 16 "diagnostic categories" listed in the HCFA release reveal no problematical data. All mortality rates in the data release for Moss Regional Hospital are well within the range of predicted mortality rates and usually around the mid-line of the data or lower. We are pleased to find that there are no potential problem areas revealed in the HCFA mortality data for Moss Regional Hospital.

Thank you for the opportunity to participate in your efforts to develop and perfect measures of health care quality and to include our comments in the final publication of the mortality data.

Sincerely,



Edward G. Poor
Hospital Director

EJGH
East Jefferson General Hospital

PETER J. BETTS, FACHE
PRESIDENT AND
CHIEF EXECUTIVE OFFICER

4200 Houma Boulevard
Metairie, Louisiana 70011
(504) 454-4000

October 26, 1987

Mr. Harvey Brook
Health Standards and Quality Bureau
Hospital Mortality Information
Room 2D2 - Meadows East Building
6300 Security Boulevard
Baltimore, Maryland 21207

Re: Medicare No. 190146

Dear Mr. Brook:

We are in receipt of HCFA's Mortality Data release and are pleased to note that, in each category, we lie well within the predicted range. We would like to comment, however, on some of the specifics regarding our facility. The actual mortality experience at this institution will be influenced by several factors that are not accounted for by your methods. Factors such as the fact that East Jefferson General Hospital is a tertiary care facility with over 600 physicians on staff. Most of these physicians are specialists, either board certified or board eligible, attracting transfers of the most ill types of patients. The fact that East Jefferson General Hospital is the largest and most technologically advanced community hospital in our service district; and the fact that we are the only public hospital in our service district and therefore provide for segments of the population recognized as having the poorest health status yet who are not attractive as patients to other nonpublic hospitals in our area are not accounted for. The fact that the numbers of catastrophic cases treated here continues to increase is also not accounted for.

Our mortality rate can be adversely influenced by the fact that the East Jefferson General Hospital has the second largest emergency room in the state, attracting more patients than any other except Charity Hospital of New Orleans. This high visibility in the community as a facility of excellence in emergency medicine attracts more than our share of seriously or

Board of Directors: Robert Murphy, Chairman, Orris S. Bennett, Joseph C. Domino, Charles Eckert, M.D., Donald S. Kerr, John Manzella, Jr., Robert McHardy, M.D., Francis Nelson, Jacob Sciambra, Sie L. Terrell, Henry K. Threefoot, M.D., Joseph Yenni

critically ill or injured patients; those more likely not to survive. A comment must be made about the applicability of your statistics for cancer deaths. Our institution has a center of excellence in a dedicated cancer treatment unit, the "Center for Living with Cancer." Most of the patients attracted to this facility already have failed primary treatment, have metastases and are on chemotherapy. Many are cured or have increased survival, but the presence of such a unit must increase the calculated mortality rate above that of institutions not having such a unit. In addition, the hospital has a hospice program for those cancer patients known to be incurable. The same logic applies to deaths due to heart and vascular disease in a tertiary referral institution of national reputation such as the East Jefferson "Gulf South Heart Center." We understand that the HCFA statistics to be released are not adjusted for the above factors and therefore are not useful for comparison between nonidentical institutions. Our case mix index for severity of cases as published in the Federal Register is 1.3315, well above the national average of 1.0.

The HCFA mortality information is neither the only nor the best indicator of quality at our hospital. East Jefferson General Hospital has a complete quality assessment program that has been in place since 1980. At our last inspection by the Joint Commission on Accreditation, our quality assessment program was approved for three years without contingency. Through this program and through the clinical departments, every death listed on the HCFA release occurring in the hospital had already been individually reviewed and investigated and found to have occurred in spite of high quality appropriate medical care. As a matter of fact the public should be reassured to know that the care rendered to every patient who dies at East Jefferson General Hospital is reviewed by the quality assessment mechanism of the Medical Staff. This is a much more appropriate measure of quality than the release to the public of mortality rates. In addition, we have never been notified by the local governmental review agency, the PRO, of any quality of care problems related to these deaths. It should be noted that of the deaths reported by HCFA, approximately 12% occurred after the patient had been discharged from the hospital.

East Jefferson General Hospital and its Medical Staff are committed to providing high quality medical care to the citizen of our hospital service district. Ongoing mechanisms within the institution to monitor and improve quality of care constitute the only true index of quality. Comparisons of predicted and observed mortality rates among hospitals is inappropriate and possibly misleading.

Sincerely yours,

Peter J. Betts, FACHE
President and
Chief Executive Officer

Samuel A. Leonard, M.D.
Sr. Vice President and
Medical Director

PJB/SAL/am

State of Louisiana
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF HOSPITALS
EARL K. LONG MEMORIAL HOSPITAL
5825 AIRLINE HIGHWAY P. O. BOX 52999
BATON ROUGE, LOUISIANA 70805
(504) 356-3361

EDWIN W. EDWARDS
GOVERNOR

SANDRA L. ROBINSON, M.D., M.P.H.
SECRETARY

October 20, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Thank you for this opportunity to respond to the release of data on hospital mortality rates that occured during 1986. Since receiving the report, Earl K. Long Memorial Hospital staff has had an opportunity to review the data.

Our Quality Assurance Department has validated that the data issued is correct. All cases reflected in this report have been reviewed. All patient deaths are monitored by a medical staff committee on an on going basis for appropriateness of care.

Earl K. Long Memorial Hospital is a 168 bed acute care teaching hospital affilated with the Louisiana State University School of Medicine. We supply quality medical care to any Louisiana citizen regardless of their ability to pay. Currently, eighty-three (83%) of our patients fall below the federal standard for poverty. These patients frequently have more severe medical conditions related to a less healthy lifestyle and inability to obtain preventative healthcare.

We are requesting that you delete the category of Sepsis from our hospitals data release. Your results indicate that we have a one hundred (100%) death rate in this area. We feel your results cannot be considered valid as only one (1) case was used in determining the death rate.

The following summarizes our findings by diagnostic catagories:

I. Metabolic/Electrolyte Disturbances
Our actual mortality rate is forty percent (40%) while our predicted range is 7 to 49%.
It should be noted that:
-- the average age of patients in this category is 82 years old.
-- four of these patients were admitted for terminal care at a NO CODE status.
-- all patients had multiple complications from chronic disease.

II. Pulmonary Disease
Our actual mortality rate is twenty-five (25%) while our predicted range is 7 to 33%.
It should be noted that:
-- the average age of patients in this category is 74 years old.
-- all patients had multiple complications from chronic disease.
-- many of these patients required ventilator management for complications of their respiratory problems.

III. Severe Acute Heart Disease
Our actual mortality rate is fifty-seven (57%) while our predicted range is 18 to 57%.
It should be noted that:
-- the average age of patients in this category is 70 years old.
-- sixty-one (61%) of the patients had a history of two or more Heart Attacks in the past.
-- all patients had multiple complications of chronic disease.

The medical staff at Earl K. Long Memorial Hospital will continue to monitor all mortality cases to assure quality medical care has been provided to our patients.

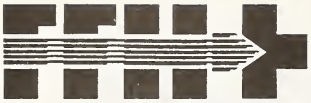
Again, thank you for this opportunity to present our response. If you have any questions regarding this information release, please do not hesitate to call.

Sincerely,

William C. Bankston
Chief Executive Officer

Larry J. Hebert, M.D.
Acting Medical Director

WCB/CC/jam



FRANKLIN FOUNDATION HOSPITAL

COMMENTS ON THE HCFA MORTALITY DATA

OCTOBER 12, 1987

REMARKS ON METHODOLOGY

Although the reliability of the model is unknown, it does appear to be quite limited. At best, it provides accurate and reliable estimates of the relationship between each of the five patient characteristics and the risk of death. It is not known if these characteristics are the most significant factors. Additionally, changes in the way certain patient characteristics are measured result in changes in the predicted mortality rates for individual hospitals. There remains some dispute over the correct way to measure such.

The model fails to consider a wide range of other factors which may have a significant impact on mortality. These include, but are not limited to, the patient's general health status, the stage of the patient's illness, the patient's psychological condition and the degree of family support.

The fact that the model has not been validated also is a source of concern. Deviations from the predicted mortality rate could indicate a quality problem, but could also reflect the exclusion from the model of significant factors influencing the risk of death. Quality judgements can only be made by carefully reviewing the information contained in the patient's medical record.

The data are not measures of hospital performance. At best, they can be used to better focus quality assurance activities. Under no circumstances should they be used as the basis for judging the quality of care provided by different hospitals.

INTERPRETIVE REMARKS

This hospital remains committed to ensuring the delivery of high quality services and therefore maintains a comprehensive quality assurance program which includes a case by case review of deaths. A variety of screening mechanisms are utilized to monitor and evaluate the quality of services and outcomes in every clinical department. This individual case analysis is the key to evaluating and ensuring quality and should be distinguished from statistical efforts to measure quality .

Post Office Box 577 • Franklin, LA 70538-0577 • (318)828-0760

The HCFA analysis assumes that the patients admitted to all hospitals are similar except with respect to the specific characteristics included in the model. It would appear that the role of the hospital in the community and the services offered by such would influence the types of patients admitted.

As a small community hospital in a rural section of the South, many patients with chronic or terminal illnesses are cared for at home and admitted to the hospital when close to death. This social phenomenon is substantiated by the fact that 46.2% of the inhouse deaths occurred within two (2) days of admission. Additionally, a large number displayed the presence of what HCFA considers "significant comorbid conditions". Although this patient may have been previously admitted on several occasions to a large urban hospital in order to receive specialty care, their death is assigned to the hospital of last admission, the rural hospital in their small community. It should also be noted that 53.6% of all patients admitted during the 1986-87 fiscal year were admitted through the hospital's emergency department. This may imply that the hospital is involved in the inpatient care of an extremely acute population which may affect mortality rates.

CLOSING REMARKS

Due to the numerous areas of uncertainty and the existence of multiple variables which have been excluded from the model, this data should not be utilized as the basis for judging the quality of care provided by different hospitals.

October 19, 1987
Date

Kyle P. Viator, Administrator

FRANKLIN PARISH HOSPITAL

2106 Loop Road
WINNSBORO, LOUISIANA 71295

October 20, 1987

William L. Roper, M. D., Administrator
Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to provide input on the mortality information concerning Medicare patients treated in our hospital in 1986.

Franklin Parish Hospital is a rural 59 bed acute care hospital serving the needs of approximately five local nursing homes.

The hospital specific mortality data reported by HCFA has been carefully reviewed by myself, as well as the Medical Staff, Director of Medical Records and members of the Quality Assurance Committee.

The Medical Staff at this hospital conducts an ongoing review of the medical record of every patient who expires at this facility regarding medical management and overall care. In addition, we have an effective quality assurance program and problems are addressed as they are identified.

Again, thank you for allowing us the opportunity to append this statement to our data.

Sincerely,

John A. Cuny, Administrator

JAC:sj

Glenwood
REGIONAL MEDICAL CENTER

October 21, 1987

William L. Roper, M. D.
Health Care Financing Administration
Health Standards Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Glenwood Regional Medical Center is an acute care facility that is Joint Commission Accredited and licensed to operate 210 beds. Our services include; cardiac care, intensive care, oncology, chemical dependency, and skilled nursing as well as general medicine and surgery. In addition, we accept critical patients from outlaying hospitals in our service area.

A team consisting of utilization review, medical records and administration has reviewed this mortality data, and it appears reasonable. However, this information does not measure quality of care or severity of illness. We feel that release of this type of mortality information could cause confusion without further information on how ill the patient was at the time of admission, whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, the patient's psychological state, general health status or other factors which affect mortality rates.

Furthermore, Glenwood Regional Medical Center's quality assurance committee monitors all deaths in our facility on a continual basis. We believe that our monitoring system provides us with accurate feedback and helps us to achieve quality of care standards.

The survey is based on medicare patients that were treated in our hospital in 1986. These figures include patients that expired in our hospital as well as those that died within 30 days of their last admission. The average age of the patients included in our mortality data was 78.

P.O. BOX 35805 WEST MONROE, LOUISIANA 71294-5805 (318) 329-4200

In conclusion, I would like to stress that we review all hospital deaths on a continual basis. It is imperative that you keep in mind the limitations of this data. Furthermore, differences in mortality data between area hospitals should not be interpreted as difference in quality of care rendered.

Thank you for this opportunity to respond to this survey.

Sincerely,

Larry D. Rentfro
Chief Executive Officer

HARDTNER MEDICAL CENTER

M. L. BARKSDALE, ADM.
BOX 1218 OLLA, LOUISIANA 71465
TELEPHONE AC 318 495-3131

BOARD OFFICERS
L. WOODS, Chairman
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B. ZEAGLER

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Mortality review is part of the patient care evaluation process at Hardtner Medical Center. Our Medical Staff monitors each case for the quality and appropriateness of care. Any problem identified, no matter how small, is a cause for our concern and is dealt with promptly and effectively. After receiving mortality information about Medicare patients in our hospital in 1986, review revealed that one patient was admitted in the low risk category of GU: Urological disease. After medical review of this case, it was determined that the actual cause of death was in the high risk category of renal disease. Due to the severity of disease and terminal illness, all in-hospital deaths were anticipated from the time of admission. One post-discharge death was reported and after review of the medical record it was confirmed that high quality care was delivered even though death was unexpected.

Sincerely,

M. L. Barksdale

M. L. Barksdale
Administrator

ss

HCA North Monroe Hospital

Dr. William L. Roper Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

October 28, 1987

Dear Dr. Roper,

We are writing in response to the 1986 mortality information released by your office in September.

These data have been review by the hospital Administration, Quality Assurance and Utilization Review Committees and seem reasonable.

HCA North Monroe Hospital is an acute care facility serving patients from the city of Monroe and the surrounding area of approximately 100 miles, including Southeastern Arkansas. We accept transfers from other acute care hospitals and nursing homes in our vacinity.

Your data simply reflects Medicare patients and is by no means a measurement of the quality of care given by a hospital. It does not take into consideration the severity of illness or complicating conditions of the patients.

It should be noted that every death in our hospital is reviewed by a Medical Committee and no Quality problems have ever been identified. We are a Joint Commission on Accreditation of Hospitals approved facility and have not been placed on intensified review by the Peer Review Organization for Medicare.

We appreciate you sharing this information with us and allowing us to respond.

Sincerely;

Arlen B. Reynolds, Administrator

Provider number 190197
3421 Medical Park Drive
P.O. Box 7050
Monroe, Louisiana 71211
Telephone (318) 388-1946
A Subsidiary of HCA The Healthcare Company

HCA Highland Hospital

October 26, 1987

William Roper, M.D.
Administrator
Dept. of Health & Human Resources
Health Care Financing Administration
Washington, D.C. 20201

Re: Mortality Statistics

Dear Dr. Roper:

Thank you for the opportunity to append this letter with the data collected by HCFA on our hospital's mortality rates. Even though Highland Hospital did not fall outside of predicted norms for mortality, we did an indepth review of the data to identify any falacies and to grasp a better understanding of the data's meaning specific to our hospital.

A Committee was formed consisting of the Medical Records Director, Utilization Review Coordinator, Director of Nurses, Chief of Staff and Administrator to evaluate the findings. Included in these findings were several errors on your part which we feel need addressing.

- o Thirteen patients had an incorrect age listed according to our records.
- *o Four patients had incorrect dates of death according to the records and death certificates in our files.
- *o One patient had an incorrect last date of admission-discharge.

*These errors resulted in you identifying five patients as dying after discharge when in fact they did expire in the hospital.

Highland Hospital takes pride in our Quality Assurance program that monitors every aspect concerning patient care, including an indepth review of all mortalities. We believe that our monitoring system is highly effective in helping to meet and exceed quality care standards.

Again, thank you for this opportunity to clarify the mortality data.

Sincerely,

Ron Elder
Ron Elder
Administrator

Alan B. Grosbach, MD
Alan Grosbach, M.D.
Chief of Staff

1006 Highland Avenue
Shreveport, Louisiana 71101
Telephone (318) 227-2221

Patients Identified With Incorrect Information

Wrong dates of death:

1) Our records show Date of Death as 3-08-86
2) Our records show Date of Death as 11-12-86
3) Our records show Date of Death as 10-10-86
4) Our records show Date of Death as 8-22-86

Wrong last date of Admission/Discharge:

Our records show this patient admitted on 12-19-86 through 1-3-87 with expiration of 1-3-87.

Wrong Patient ages:

1) We show age of 68
2) We show age of 76
3) We show age of 89
4) We show age of 75
5) We show age of 73
6) We show age of 80
7) We show age of 74
8) We show age of 64
9) We show age of 71
10) We show age of 96
11) We show age of 80
12) We show age of 90
13) We show age of 96

AMI Highland Park Hospital

October 20, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
P. O. Box 26684
Baltimore, Maryland 21207

Dr. Dr. Roper,

Thank you for the opportunity to respond to the data release on hospital mortality rates for January 1, 1986 through December 31, 1986.

AMI Highland Park Hospital is a 104 bed medical center which specializes in the delivery of acute comprehensive medical and surgical care, providing services to the St. Tammany Parish communities and its surrounding areas.

Highland Park believes, just as your office believes, that the quality of care rendered at our facility should be monitored and evaluated. This is why our hospital requires that our medical staff and clinical staff form active committees to monitor the quality of our patient care and services. These committees monitor such areas as mortality, appropriateness of care and the continuity of services just to name a few.

Evaluating and monitoring the hospitals performance in these areas helps insure that Highland Park Hospital continues to provide high quality of care to its community.

The hospital specific mortality data report released by your office has been reviewed by our administrative and medical staff. As your report indicates, our percentage of deaths is well within the lower half of the mortality rates predicted by your office.

Again, thank you for the opportunity to present this response.

Sincerely,

Jerry Peterman,
Executive Director

Post Office Drawer [illegible]

Hood Memorial Hospital

A. D. RICHARDSON
ADMINISTRATOR

AMITE, LOUISIANA 70422

301 WEST WALNUT
TELEPHONE 748-9485

October 14, 1987

William L. Roper, M. D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

RE: Mortality Statistics October 1, 1984-
September 30, 1986

Hospital I.D. # 190147

Dear Dr. Roper:

Hood Memorial Hospital is a forty-five (45) bed, acute care facility, whose case list includes patients with medical and surgical illnesses.

Administration, Medical Records, and the Medical Staff has had the opportunity to review the findings in this report. This data has been validated and with minor exceptions, is accurate.

The Medical Staff of Hood Memorial Hospital, as has been their practice, will continue to review mortality cases for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews is a constant indeavor to assist in identifying opportunities to improve care.

While this data has been verified to be basically correct, the following points should be noted:

* The average age of all deaths listed in this report was approximately 82 years old.

* Of 42 deaths listed, 15 were not at Hood Memorial Hospital at the time of their death.

* Hood Memorial Hospital falls well within the range of predicted mortality rates, with the exception of 1 case. In this particular case, it should be noted that:

  * The sampling size in this particular area was not large enough to be of statistical significance, as there was only one case.

  * Patient's condition was such that the family had requested that no CPR or heroic measures be performed.

RE: Mortality Statistics

It is imparative that any reviewer keep in mind the limitations of this summary data by DRG which dees not reflect the difference in diagnosis, procedures, severity of illness, case mix, age, complications, and reason for death. Differences in data between hospitals should not be interpretated as a difference in quality of care.

Again, thank you for the opportunity to present this response.

Sincerely,

A. Danny Richardson
Administrator

ADRrc

Hôtel Dieu HOSPITAL
2021 PERDIDO STREET • P. O. BOX 61262 • NEW ORLEANS, LOUISIANA 70161 • (504) 588-3000

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
P.O.Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for the opportunity to respond to the release of statistical data concerning Hotel Dieu's Medicare mortality rates for the twelve (12) month period ended December 31, 1986. Our Director of Quality Assessment and Case Management has verified the information and confirmed that the mortality figures released by the Health Care Financial Administration (HCFA) were well within the predicted mortality range.

It should be noted, however, that based on our Medicare discharge records for 1986, the overall death rate was calculated to be 10.1 percent instead of the 12.1 percent as reported by HCFA. If HCFA's figures were adjusted for this unfavorable 18 percent discrepancy, Hotel Dieu's overall death rate would have been reported to be even closer to the lower end of the predicted range.

Hotel Dieu Hospital is an acute care facility with 272 staffed beds. We are a full service medical center affiliated with a medical school program and offer care in specialty areas of oncology, renal transplant, dialysis, open-heart surgery, bone-marrow transplant, ophthalmology and major orthopedic procedures, as well as general medicine and surgery. Additionally, Hotel Dieu is one of a few healthcare providers, in the greater metropolitan area, with a Hospice Program that provides comprehensive care and comfort to terminally ill patients.

The Medical Staff performs an intensive review of the medical records of every patient who expires at Hotel Dieu to determine the appropriateness of care. Mortality review continues to be a significant part of an on-going process of the Quality Assessment Program. When quality problems are identified, corrective action is taken immediately.

The specific mortality data was closely reviewed by the President of the Medical Staff, Physician Chairman of the Quality Assessment Committee, Director of Quality Assessment, and Administration. Although we were within the predicted range for all reported major diagnostic categories, the following comments relative to high risk groups of cancer, stroke and sepsis deaths deserve recognition:

- Between thirty-seven to forty-six percent of patients in these three categories were identified as being severely ill or terminal, by their physician, at the time of admission. The advanced stage of health deterioration made survival very slim for these patients.
- Many of these patients were referred directly to the hospital's hospice program or other subacute facilities for terminal care.
- The average age of patients, at the time of death, in these high risk categories was 77 years.

As a member of the Daughters of Charity National Health System and a facility accredited by the Joint Commission (JCAH), we consider a practice of high quality care to be consistent with our healthcare mission. We feel, however, that mortality rates alone should not be the only measure of quality in healthcare and therefore, we challenge and support the American Hospital Association and other organizations, in their efforts, to develop a more comprehensive plan to measure quality standards.

Sincerely,

Sister Regis Maillian

Sister Regis Maillian
President, Hotel Dieu

Robert Schramel, M.D.

Robert Schramel, M.D.
President, Medical Staff

SRM/jk

130 North Hospital Drive
P.O. Box 609
Oakdale, Louisiana
71463
Telephone 318 335-[illegible]

Humana Hospital
Oakdale

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital Oakdale supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Healthcare Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the the quality of a particular hospital's services.

As in all deaths occuring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw

mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records and quality assurance staff have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

Our hospital is the only hospital serving a primary service area radius of over 20 miles.

Specifically, we reviewed all categories and under category HS--severe acute heart disease--there were seven deaths out of nine cases. The average age of the patients in this group was 76 years of age. The average length of stay for these patients was 2.5 days. Four of the seven patients had hospital stays of 12 hours or less and were intubated within one hour of arrival at the hospital, reflecting the seriousness of their condition. One patient was admitted from a nursing home. One patient with a length of stay of two days was actually declared brain dead and the two-day length of stay was incurred because of waiting for results of the second EEG. All of these patients were treated for acute myocardial infarction. All deaths were reviewed by our medical staff.

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Yours very truly,

Louis J. Deumite

Louis J. Deumite
Executive Director

and

George R. Mowad, M.D.

George R. Mowad, M.D.
President, Medical Staff

LJD/GBM:jl

P.O. Box 152
301 West Bourgeois
Winnfield, Louisiana
71483
Telephone 318 628-27[illegible]

Humana Hospital
Winn Parish

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Thank you for the opportunity to commend on the hospital specific mortality data provided to us late last month. Humana Hospital-Winn Parish supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records department has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Lloyd C. Dupuy
Executive Director

LD/ijc

P.O. Box 255
Highway 167
Marksville, Louisiana
71351
Telephone 318-253-8611

Humana Hospital
Marksville

October 23, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Marksville supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding this extensive quality control systems in place in hospitals.

Our hospital's medical records and quality assurance staff have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable "standards."

Specifically, we reviewed all categories and find:

A. In the category SE, in both deaths we found that the families requested that no extra ordinary measures be taken should the patients require Cardio Pulmonary Resusitation.

B. The census category included only 2 patients. We do not feel that it is possible to provide a valid statistical analysis with this small sample.

C. After reviewing all categories, we have found that the care given these patients was appropriate.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Lloyd C. Dupuy

Lloyd C. Dupuy
Executive Director

LCD/nnd

P O Box 29504
New Orleans, Louisiana
70189
Telephone 504 241-6335

Humana Hospital
New Orleans

October 21, 1987

William L. Roper, M.D.
Administrator, Health Care
Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital New Orleans supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is

useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limites scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's Quality Assurance has reviewed the data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

Specifically, we reviewed all diagnostic categories at Humana Hospital New Orleans and found appropriate care rendered in all cases. We have reviewed all categories and find under one category, sepsis, we had one case, one death or 100% actual mortality rate. The predicted range is 3-99%. As you can see, again, we have a statistically invalid rate because of the number of cases performed for this diagnostic category.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can be used to improve health care services.

Sincerely,

Jimmy LeDoux,
Executive Director

JL/pl

cc: Patrick Stone, Senior Public Affairs Manager
Patricia Davis, Regional Vice President

P.O. Box
Humana Blvd
Springhill
Telephone

Humana Hospital Springhill

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Springhill supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

Humana Hospital - Springhill is an 86 bed acute care facility, whose case mix includes medical, surgical, and intensive care patients. Over fifty percent (50%) of this facility's inpatients are elderly and there are three (3) sizeable nursing homes in our immediate area, whose patients utilize this facility.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbitity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treament outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

The hospital specific mortality data reported by the Health Care Financing Administration has been reviewed by the Executive Director, Associate Executive Director of Finance, Associate Executive Director of Nursing,

Medical Records Director, DRG/Quality Assurance Coordinator, and Medical Staff. The Board of Trustees will review them at their next meeting. Overall our average fell within the Health Care Financing Administration's predicted ranges for this facility.

Overall quality of care is monitored on an on-going basis here at Humana Hospital - Springhill.

Thank you for the opportunity to respond to this 1986 data release.

Sincerely,

Ronald P. O'Neal

Ronald P. O'Neal
Executive Director

RPO:bs

800 East Main Street
P.O. Box 349
Ville Platte, Louisiana
70586
Telephone 318 363 5011

Humana Hospital
Ville Platte

October 23, 1987

William L. Roper, M. D., Administrator
Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Ville Platte supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients.

Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records, quality assurance, and medical staff have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

James C. Colligan
Executive Director

JCC/em

Iberia General Hospital and Medical Center
"Professional Care With The Personal Touch"

IRVIN BREAUX, CHAIRMAN
BOARD OF COMMISSIONERS

DONALD R. HEBERT
EXECUTIVE DIRECTOR

October 20, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

RE: Hospital Mortality Data

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics which we understand will be published in our local newspapers in December 1987.

We have reviewed the statistics with specific emphasis in the areas where we were at or near the high side of the predicted ranges. In the vast majority of the cases, the patients were quite elderly, and had multiple medical conditions which had significant contribution to the overall ill-health of the patients.

We are a 130 bed hospital in rural Louisiana with a high population of persons 65 and older. Approximately 40% of our monthly admissions (60% of all in-patient days) are beneficiaries of the Title XVIII Program. We strongly feel that due to the horrendous economic problems being experienced in an area almost totally dependent on oil and its related products, the percentage of elderly admissions to our facility would only increase; hence, a high propensity to treat those with multiple medical problems who, although we practice quality care, could die while in our institutions or certainly within 30 days post-discharge. It is imperative that any person attempting to evaluate the data that will be published keep in mind that the summary data does not reflect the differences in diagnoses, procedures, severity of illness, case mix, age, complications, etc. Further, differences in data between hospitals in the same locale should not be interpreted as a corresponding difference in the quality of care delivered by the health care facilities.

Again, thank you for the opportunity to respond.

Sincerely,

Donald R. Hebert

Donald R. Hebert
Executive Director

2315 East Main Street • P. O. Box 1450 • New Iberia, Louisiana 70561-1450 • (318) 364-0441

WILLIAM BROUSSARD
PRESIDENT

SADAY MANUEL
SECRETARY · TREASURER

JCAH APPROVED

HAZARD GUILLOT
VICE · PRESIDENT

TERRY J TERREBONNE
ADMINISTRATOR

JENNINGS AMERICAN LEGION HOSPITAL

NORTH HIGHWAY 26
BOX 1027
JENNINGS, LOUISIANA
70546

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Provider Number: 190053

Dear Dr. Roper,

Thank you for the opportunity to respond to the release of data on our hospital's mortality rates for 1986.

Our hospital is a 49 bed, non-profit acute care facility with physicians on staff who specialize in internal medicine, surgery, radiology, family practice, obstetrics/gynecology and pediatrics. Urology, orthopedic and podiatry clinics are held here on a weekly basis. We are a small community hospital, yet we provide sophisticated and up-to-date diagnostics and treatment. Because of our rural location, we treat a large number of geriatric patients, with the majority of our patient population, 51.2%, being Medicare.

Our Medical Staff, as part of its quality assurance program, routinely reviews all hospital deaths in order to assess the care provided. Through this quality review, problems or trends may be identified and acted upon. Mortality review is only one aspect of the hospital's ongoing quality assurance monitoring, which encompasses all areas of direct and non-direct patient care and is performed by all personnel.

Our Quality Assurance Coordinator verified the HCFA mortality data, and with a few exceptions, all information was accurate. The hospital's Utilization Review Committee is composed of members from Administration, the Medical Staff, Nursing Service and other ancillary departments. The committee reviews appropriateness of utilization of services throughout the hospital.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

In reviewing the data, the Utilization Review Committee noted that we were well within acceptable norms in all categories. (One exception was the category for severe trauma, in which the number of cases, one, was too small to be of significance.) It should be understood that in 30% of the cases reported, death occurred outside the hospital. These cases were all carefully reviewed by the committee to determine that the care provided was appropriate.

The Medical Staff of the Jennings American Legion Hospital will continue to monitor services provided to assure that all patients receive care that meets or exceeds acceptable standards of quality. The objective of this review is the realization of opportunities to improve patient care.

Again, we thank you for the opportunity to present this response.

Sincerely,

Terry J. Terrebonne
Administrator

TJT/dld

Jo Ellen Smith MEDICAL CENTER
4444 GENERAL MEYER AVENUE/NEW ORLEANS, LOUISIANA 70114/(504) 363-7011

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir/Madame:

RE: Mortality Statistics
January 1, 1986 - December 31, 1986

Dear Mr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for January 1, 1986 through December 31, 1986.

We are pleased to note that of sixteen diagnostic categories identified, Jo Ellen Smith Medical Center ranked in the lower one-half of predicted mortality rates for all sixteen (16) categories.

Our Medical Center specializes in the delivery of acute level comprehensive medical rehabilitation to patients with a wide spectrum of etiologies for their disabilities. Additionally, we have intensive care units, and tertiary referral services for Skilled Nursing, Convalescent Care, Psychiatric, as well as Nursing Home Facilities.

Since receiving the report, Jo Ellen Smith Medical Center Quality Assurance's staff has had an opportunity to review the data. The Director of Quality Assurance has validated that, with a few exceptions, the presented data is accurate. All cases reflected in this report have been reviewed.

On an on-going basis, appropriate clinical departments have always reviewed every mortality in our facility for appropriateness of care. As well, all Medicare patient cases are routinely reviewed at discharge for appropriateness, and adequacy of planning.

During the year of 1986, Jo Ellen Smith Medical Center had 1,704 Medicare admissions, 1,618 Medicare discharges and 96 Medicare deaths. The HCFA report reflects 119 Medicare deaths, with the average age being 77.7 years; one patient was age 100; one patient was age 48; these were the upper and lower age-values in this group.

Upon review, the cases with variations from the presented data fell into seven general classifications:

CLASSIFICATION NO. 1

Information on this patient concurs with hospital records, no correction of your data is necessary.

- 76 patients (64% of study group) were included in this classification.

CLASSIFICATION NO. 2

2) Patient indicated as expired outside of our facility; however, was found to have expired at our facility with date of death requiring correction on your data.

- 6 patients (5% of study group) were included in this classification.

DATE OF DEATH 08/16/86
DATE OF DEATH 09/18/86
DATE OF DEATH 06/06/86
DATE OF DEATH 12/19/86
DATE OF DEATH 05/22/86
DATE OF DEATH 03/22/86

CLASSIFICATION NO. 3

Patient expired at our facility as indicated, but your listed Primary Diagnosis was not accurate, requiring correction on your data.

- 19 patients (16% of study group) were included in this classification. (Note: See Attachment A)

CLASSIFICATION NO. 4

Patient expired outside of our facility as indicated on your data; our records indicate more accurate diagnoses/complications which indicate that patient death was not unexpected.

- 7 patients (6% of study group) were included in this classification.

CLASSIFICATION NO. 5

Patient expired outside of our facility as indicated on your data; patient was discharged in fair to poor condition and death was not unexpected.

- 6 patients (5% of study group) were included in this classification.

CLASSIFICATION NO. 6

No record of these patients at this facility..

- 4 patients (3% of study group) were included in this classification.

CLASSIFICATION NO. 7

Patient expired outside of our facility on December 23, 1986. This case was an E.R. visit due to an automobile accident and the patient was released and sent home that day. An outpatient thorocentesis was performed on 12/11/86 as prescribed by the patient's attending physician.

- 1 patient (1% of study group) was included in this classification.

In summary, the above response indicates that 36% of the data you submitted to us was inaccurate. It is imperative that any reviewer keep in mind the limitations of this summary data by ICD-9-CM primary codes. The data as your report indicates, does not reflect the differences in diagnoses, procedures, severity of illness, case mix, age, complications and reason for death. Differences in data between hospitals should not be interpreted as a difference in quality of care administered.

CLASSIFICATION NO. 5

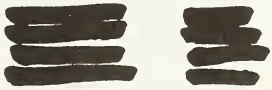
Patient expired outside of our facility as indicated on your data; patient was discharged in fair to poor condition and death was not unexpected.

- 6 patients (5% of study group) were included in this classification.

CLASSIFICATION NO. 6

No record of these patients at this facility..

- 4 patients (3% of study group) were included in this classification.



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- 1 patient (1% of study group) was included in this classification.

In summary, the above response indicates that 36% of the data you submitted to us was inaccurate. It is imperative that any reviewer keep in mind the limitations of this summary data by ICD-9-CM primary codes. The data, as your report indicates, does not reflect the differences in diagnoses, procedures, severity of illness, case mix, age, complications and reason for death. Differences in data between hospitals should not be interpreted as a difference in quality of care administered.

Again, thank you for the opportunity to clarify and expand on this mortality data.

Sincerely,

Ronald G. Ensor
Administrator

RJE/jk

wp0803K

Attachment A

CASE #	PATIENT NAME	DIAGNOSIS /	DESCRIPTION	PROCEDURE /	DESCRIPTION
[redacted]		730.27	OSTEOMYELITIS,FOOT/ANKLE	38.91	ARTERIAL CATHETERIZATION
		599.0	UTI	87.03	CAT HEAD
		780.3	CONVULSIONS	92.14	BONE SCAN
		041.1	STREPTOCOCUS INFECTION	89.14	EEG
		437.9	UNSPECIFIED CVA		
		619.1	DIGESTIVE-GENITAL TRACT FISTULA		
		250.91	IDDM WITH COMPLICATIONS		
		250.01	IDDM		
		362.01	DIABETIC RETINOPATHY		
		278.0	OBESITY		
[redacted]		799.1	RESPIRATORY FAILURE	37.21	RIGHT HEART CATHETERIZATION
		410.9	ACUTE MYOCARDIAL INFARCTION,NOS	38.91	ARTERIAL CATHETERIZATION
		414.0	CORONARY ATHEROSCLEROSIS	88.72	HEART ULTRASOUND
		437.9	UNSPECIFIED CVA	89.65	ARTERIAL BLOOD GAS MONITORING
[redacted]		799.1	RESPIRATORY FAILURE	31.1	TEMPORARY TRACHEOSTOMY
		578.9	HEMORRHAGE OF GI TRACT,NOS	38.93 X 2	OTHER VENOUS CATHETERIZATION
		585	CHRONIC RENAL FAILURE	38.91	ARTERIAL CATHETERIZATION
		530.1	ESOPHAGITIS	89.65	ARTERIAL BLOOD GAS MONITORING
		486	PNEUMONIA,NOS		
		492.8	OTHER EMPHYSEMA		
		553.3	DIAPHRAGMATIC HERNIA		
		599.0	UTI		
[redacted]		441.1	RUPTURED THORACIC ANEURYSM	38.64	AORTA,OTHER EXCISION OF VESSEL
		427.5	CARDIAC ARREST	54.5	LYSIS OF PERITONEAL ADHESIONS
				54.11	EXPLORATORY LAPAROTOMY
				89.65	ARTERIAL BLOOD GAS MONITORING
				99.04	TRANSFUSION OF PACKED CELLS
[redacted]		780.0	COMA AND STUPOR	96.07	INSERTION OF NG TUBE
		780.6	PYREXIA OF UNK. ORIGIN		
		191.9	MALIGNANT NEOPLASM OF BRAIN,NOS		
[redacted]		682.3	CELLULITIS OF UPPER ARM,FOREARM		
		ADMIT 10/24	W/ 519.8 DISEASE OF RESPIRATORY SYSTEM,NOS		
[redacted]		997.4	GASTROINTESTINAL COMPLICATIONS	54.5	LYSIS OF PERITONEAL ADHESIONS
		560.81	INTESTINAL OBSTRUCTION,OTHER	46.43	REVISION OF STOMA OF LARGE INTESTINE
		280.81	IRON DEFICIENCY ANEMIA	45.02	OTHER INCISION OF SMALL INTESTINE
		578.9	HEMORRHAGE OF GI TRACT,NOS	44.2	PYLOROPLASTY
		530.2	ULCER OF ESOPHAGUS	51.22	TOTAL CHOLECYSTECTOMY
		428.0	CONGESTIVE HEART FAILURE	37.21	RIGHT HEART CARDIAC CATHETERIZATION
		569.9	DISORDER OF INTESTINE,NOS	42.24	BIOPSY OF ESOPHAGUS
		250.91	IDDM WITH COMPLICATIONS		
		527.2	SIALOADENITIS		

LA 74.5

441.4	RUPTURED THORACIC ANEURYSM	38.47	RESECTION OF ABDOM.VEIN W/ REPLACEMENT
442.2	ANEURYSM OF ILIAC ARTERY	39.25	AORTO-ILIAC-FEMORAL BYPASS
427.31	ATRIAL FIBRILLATION	89.65	ARTERIAL BLOOD GAS MONITORING
		99.04	TRANSFUSION OF PACKED CELLS
*415.1	PULMONARY EMBOLISM & INFARCTION	*37.21	RIGHT HEART CATETERIZATION
799.1	RESPIRATORY FAILURE	88.48	ARTERIOGRAPHY OF FEMORAL/OTHER ARTERIES OF LEG
493.9	ASTHMA,NOS	92.05	RADIOISOTOPE CARDIOVASCULAR STUDY
496	CHRONIC AIRWAY OBSTRUCTION,NOS	89.65	ARTERIAL BLOOD GAS MONITORING
807.02	MULTIPLE FRACTURE OF RIBS,STERNUM,LARYNX & TRACHEA		
348.1	ANOXIC BRAIN DAMAGE	31.1	TEMPORARY TRACHEOSTOMY
427.5	CARDIAC ARREST	89.14	EEG
799.0	ASPHYXIA		
410.9	ACUTE MYOCARDIAL INFARCTION,NOS		
250.01	IDDM		
*428.0	CONGESTIVE HEART FAILURE	89.65	ARTERIAL BLOOD GAS MONITORING
496	CHRONIC AIRWAY OBSTRUCTION,NOS		
593.9	DISORDER OF KIDNEY & URETER,NOS		
401.9	HYPERTENSION,NOS		
682.6	CELLULITIS OF LEG	92.11	CEREBRAL SCAN
ADMIT 3/19 W/ 162.3	MALIGNANT NEOPLASM,LUNG	ADMIT 3/19 W/ 34.22	MEDIASTINOSCOPY
198.5	METASTASES TO BONE,BONE MARROW	34.25	PERCUTANEOUS BIOPSY OF MEDIASTINUM
799.1	RESPIRATORY FAILURE	89.65	ARTERIAL BLOOD GAS MONITORING
972.1	DIGOXIN TOXICITY		
427.5	CARDIAC ARREST		
785.51	CARDIOGENIC SHOCK		
410.9	ACUTE MYOCARDIAL INFARCTION		
780.3	CONVULSIONS		
427.41	VENTRICULAR FIBBRILLATION		
244.9	HYPOTHYRODISM,NOS		
348.3	ENCEPHALOPATHY,NOS		
707.0	DECUBITUS ULCER	37.21	RIGHT HEART CATHETERIZATION
ADMIT 8/85 W/ 311	DEPRESSIVE DISORDER	ADMIT 8/85 W/ 86.22	DEBRIDEMENT OF WOUND
041.1	STAPHYLOCOCCUS INFECTION		
707.1	ULCER OF LEG		
714.0	RHEUMATOID ARTHRITIS		
413.9	ANGINA PECTORIS,NOS		
455.2	INTERNAL HEMORROIDS		
414.0	CORONARY ATHEROSCLEROSIS		
038.1	STAPHYLOCOCCAL SEPTICEMIA	86.22	DEBRIDEMENT OF WOUND
427.5	CARDIAC ARREST	89.65	ARTERIAL BLOOD GAS MONITORING
707.0	DECUBITUS ULCER		
038.40	SEPTICEMIA DUE TO GRAM-NEG.ORGANISM		
428.0	CONGESTIVE HEART FAILURE		
436	ACUTE CEREBROVASCULAR DISEASE,NOS		
*427.5	CARDIAC ARREST		

LA 746

[redacted]

785.4	GANGRENE	84.17	AMPUTATION ABOVE KNEE
785.59	SHOCK,NOS	84.3	REVISION OF AMPUTATION STUMP
998.3	DISRUPTION OF OPERATION WOUND	32.21	PLICATION OF EMPHYSEMATOUS BLEB
428.0	CONGESTIVE HEART FAILURE	89.64	PULMONARY ARTERY WEDGE MONITORING
		99.04	TRANSFUSION OF PACKED CELLS

[redacted]

785.59	SHOCK,NOS	39.93	INSERTION OF DIALYSIS SHUNT
572.2	SIALOADENITIS	39.95	RENAL DIALYSIS
251.01	IDDM	37.21	RIGHT HEART CARDIAC CATHETERIZATION
584.9	ACUTE RENAL FAILURE,NOS	38.91	ARTERIAL CATHETERIZATION
286.6	DEFIBRINATION SYNDROME	99.04	TRANSFUSION OF PACKED CELLS
282.62	Hb-S DISEASE,W/OUT CRISIS	89.65	ARTERIAL BLOOD GAS MONITORING
285.9	ANEMIA,NOS	92.15	PULMONARY SCAN
427.5	CARDIAC ARREST	92.02	LIVER SCAN

[redacted]

410.9	MYOCARDIAL INFARTION,NOS

LA 74.7

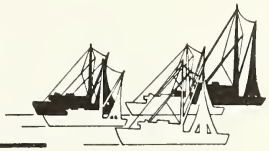
Attachment B

CASE #	PATIENT NAME	DIAGNOSIS / DESCRIPTION		PROCEDURE / DESCRIPTION	
[redacted]		#785.4	GANGRENE	#84.17	AMPUTATION ABOVE KNEE
		443.9	PERIPHERAL VASCULAR DISEASE,NOS	89.65	ARTERIAL BLOOD GAS MONITORING
		410.9	ACUTE MYOCARDIAL INFARTION,NOS	99.04	TRANSFUSION OF PACKED CELLS
		997.1	CARDIAC COMPLICATIONS		
[redacted]		Discharged 04/19/86 Known diagnosis of Pancreatic CA w/ SOB D/c'ed to home in poor condition.			
[redacted]		Discharged 03/07/86 Treated for pneumonitis until stable, transfer back to Nursing home per family wishes.			
[redacted]		Discharged 11/21/86 New R. Sided CVA D/C'ed to SNF in poor condition.			
[redacted]		Discharged 04/12/86 Transferred to Extended Care Facility stable, in good/fair condition.			
[redacted]		Discharged 02/13/86 Admit with MI, transfered to Nursing home when stable in poor condition.			
[redacted]		Discharged 02/25/86 Transferred to Nursing home after stabilization, in poor condition.			

Lady of the Sea
GENERAL HOSPITAL
P.O. BOX 68
GALLIANO, LOUISIANA - 70354

Telephone 632-6401

BARNEY T. FALGOUT, Administrator



COMMISSIONERS:

JOHN RABB, Chairman
ENA LEONARD, Vice-Chairman
LOUIS DUET, Sec.-Treas.
S.R. VIDRINE, Member
WILLIAM CRENSHAW, M.D., Member

October 26, 1987

Department of Health & Human Resources
Health Care Financing Administration
Washington, D.C.

ATTENTION: William L. Roper, Administrator

Dear Mr. Roper:

Please publish the enclosed comments when the mortality data for Lady of the Sea General Hospital is published.

Thank you for your cooperation.

Very truly yours,

Barney T. Falgout

Barney T. Falgout
Administrator

BTF:pme
encl.

H F C A
1986 MORTALITY REPORT

Upon receipt of the selected HFCA mortality information for 1986, hospital administration authorized the Quality Assurance Committee of Lady of the Sea Hospital to further investigate the HFCA data prior to publication.

Because of the relatively small number of cases involved which can easily cause distortion of percentages, it was decided to investigate and comment on the two (2) diagnostic categories in which the most deaths had occured. These diagnostic categories are as follows:

1. Pulmonary Disease
2. Severe Acute Heart Disease

In the pulmonary disease category, Lady of the Sea had 13 deaths for a 37% mortality rate. The average age of these 13 patients was 73 years (8 were over age 75 and 5 were under age 70).

Nine (9), or 69%, were admitted from the local nursing home in poor physical and mental condition. Two (2) were transferred back to the nursing home in improved condition and subsequently died. The five (5) patients under age 70 in the pulmonary disease category are addressed as follows:

1. 01-15-86 to 01-17-86 - 60 year old
   DIAGNOSIS: Bilateral Pneumonia
   Intracerebral Hemmorhage
   Chronic Schizophrenia
   Mental Retardation
   Patient was admitted from the Nursing Home and overall physical condition and mental retardation decreased his life span.

2. 08-20-86 to 08-26-86 - 63 year old
   DIAGNOSIS: Staph Pneumonia
   Staph Sepsis with Dehydration
   UTI
   Alzheimer's Disease
   Patient was admitted from the Nursing Home. Patient's overall physical and mental status was poor.

3. 03-08-86 to 03-14-86 - Expired 04-02-86 - 63 year old
   DIAGNOSIS: Pneumonia
   Acute Bronchitis
   COPD
   Gastritis
   Respiratory Acidosis
   Pulmonary Failure
   Multiple admits for COPD
   Patient admitted from Nursing Home and returned to Nursing Home where patient expired.

4. 02-03-86 to 02-07-86 - 69 year old
   DIAGNOSIS: Glioblastoma Right Hemisphere
   Pneumonia Left Lower Lobe
   Patient was terminal and admitted from Nursing Home.

5. 11-16-86 to 11-18-86 - 50 year old
   DIAGNOSIS: Pseudomonas Aspiration
   Pneumonia with Respiratory Failure
   Hypotension and Sinus Tachycardia secondary to Sepsis
   Coma secondary to Ischemic CVD
   Numerous admits. Poor physical and mental state.

Of the 13 total deaths from pulmonary disease, nine (9), or 69% were admitted from the local Nursing Home, and 15% were in terminal condition. All 13 patients were in poor physical and/or mental health prior to admit to the hospital.

In the severe acute heart disease category, Lady of the Sea had a total of 5 deaths, or a 42% mortality rate. The average age for these patients was 74 years, and all were admitted from their home. It is to be noted that two (2) of the five (5) patients refused to follow medical advice, while another arrived in the emergency room in full arrest. The remaining two (2) patients in this category had overall poor health due to age and physical condition. These five cases are addressed as follows:

1. 06-30-86 - 73 year old
   DIAGNOSIS: Acute M.I.
   Cardiogenic Shock
   Brought into E.R. in full arrest. Arrested approximately 13 minutes prior to arrival in emergency room. Coded in I.C.U. without response.

2. 02-06-86 to 02-07-86 - 66 year old
   DIAGNOSIS: Acute Inferior Wall M.I.
   Respiratory Arrest
   Adbominal Pain
   Patient was admitted with pending delirium tremors. Patient had a history of alcohol substance abuse. Overall poor health.

3. 03-25-86 to 04-01-86 - 86 year old
   DIAGNOSIS: Cardiogenic Shock
   CHF
   Renal Insufficiency
   Patient had recent admit with complaint of angina pectoris and pulmonary edema.

4. 09-17-86 - 71 year old
   DIAGNOSIS: Acute M.I.
   Patient recently discharged (08-24-86) with angina. Patient was examined by a heart specialist in New Orleans on 09-16-87 and was advised to be admitted to the hospital, however, patient refused admission. Patient subsequently came to the hospital and had cardiac arrest within 90 minutes of admission.

5. 12-07-86 - 12-08-86 - 74 year old
   DIAGNOSIS: Acute M.I.
   Atrial Fibrillation
   Physician recommended intubation and transfer to cardiac unit for balloon pump. Patient refused to be transferred and intubated. Overall condition poor and continued to deteriorate.

In summary, 18 deaths out of a total of 39 (or 46%) in 1986 were thoroughly reviewed. It showed that most patients were in poor physical or mental health and almost all deaths were predictable.

LGMC LAFAYETTE GENERAL MEDICAL CENTER

October 27, 1987

William L. Roper, M.D., Administrator
HEALTH CARE FINANCING ADMINISTRATION
HEALTH STANDARDS & QUALITY BUREAU
HOSPITAL MORTALITY INFORMATION
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The following information for Lafayette General Medical Center should be attached to the Hospital Specific Report for 1986, prior to disclosure. We fully understand that the hospital specific mortality data represents Medicare patients only and does not include considerations for the severity of illness.

Lafayette General is a 367 bed complete medical center, providing tertiary care for a large region of southwest Louisiana. Our case mix includes numerous patients with surgical and major medical needs. Along with providing general medical and surgery, we offer specialized care in the areas of intensive care, oncology, radiation therapy, open-heart surgery, orthopedic and neurological services, rehabilitation, and dialysis. We also serve as an official trauma center. Lafayette General is fully accredited by Joint Commission on Accreditation of Hospitals.

The mortality data reported by HCFA, in reference to our facility, has been reviewed by the hospital's Executive Vice President, Senior Vice President, Vice President of Fiscal Services, physician consultant of Utilization Review and Quality Assurance, Director of Medical Records, and the Mortality Data Project Team.

ACADIANA'S ONLY TOTAL SERVICE HEALTHCARE CENTER

1214 COOLIDGE AVENUE, P. O. BOX 52009 O.C.S.,
LAFAYETTE, LOUISIANA 70505 (318) 261-7991

We have found that our overall percentage of deaths is well within the predicted mortality range established by HCFA.

Mortality review is an on-going process, involving numerous individuals within our facility. To professionally monitor medical management and total care, the Lafayette General Medical Staff reviews the medical records of patients who expire at the hospital. Our Quality Assurance program provides for detailed mortality review on a regular basis.

The information provided to us by HCFA has been used as a quality assessment tool to review our mortality cases. Trending analysis from these reviews will allow us to identify opportunities and to continuously improve care.

We thank you for the opportunity to present this response.

Sincerely,

JOHN J. BURDIN, JR.
EXECUTIVE VICE PRESIDENT

kw

Lakeside Hospital

4700 I-10 Service Road
Metairie, Louisiana 70001
Tel. (504) 885-3333

October 27, 1987

Harvey Brook
Health Standard & Quality Bureau
Room 2-D-2
Meadows East Blvd.
6300 Security Blvd.
Baltimore, MD 21207

Dear Mr. Brook:

This is in response to your letter concerning the release of the mortality information for Lakeside Hospital to the news media.

Our hospital Medicare I.D. number is 190182.

It is correct that our mortality rate for HS Severe Acute Heart Disease was 100% for the reporting period of 1986. However, I do not feel that the reporting to the news media of this statistic is appropriate since we treated only one patient and obviously that is not a sufficient statistical sample in order to draw any conclusions.

We treated over 230 Medicare patients last year and experienced only 3 deaths among that population. We feel that the care given at Lakeside Hospital is well beyond the general standard.

If you have any questions, please do not hesitate to call me.

Sincerely,

Gerald L. Parton
Administrator

GLP/bkw

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF HOSPITALS
Lallie Kemp Regional Medical Center
HIGHWAY 51 SOUTH
P.O. BOX 70
INDEPENDENCE, LOUISIANA 70443

(504) 878-9421
LINC 655-1011

EDWIN EDWARDS
Governor

S.L. ROBINSON, M.D., M.P.H.
Secretary

COMMENTS ON THE HCFA MORTALITY DATA
LALLIE KEMP REGIONAL MEDICAL CENTER
INDEPENDENCE, LA

Data Verification

The data used by HCFA indicate that a total of 28 Medicare patients admitted to Lallie Kemp Regional Medical Center died within 30 days of admission. Of these, 14 died while still a patient of the hospital, while 14 died after discharge. Our own records indicate that 266 Medicare admissions occurred in 1986. Our own records also indicate that of the 28 Medicare patients who died within 30 days of admission while still an inpatient, 8 were still alive at the time of discharge. It is impossible to determine the percentage of the 8 patients dying after discharge who were in fact alive, as information concerning death is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

In 4 of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. After correcting the errors in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate remains at 4.

AN EQUAL OPPORTUNITY EMPLOYER

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

OFFICE OF HOSPITALS

Lallie Kemp Regional Medical Center

HIGHWAY 51 SOUTH
P.O. BOX 70
INDEPENDENCE, LOUISIANA 70443

(504) 878-9421
LINC 655-1011

EDWIN EDWARDS
Governor

S.L. ROBINSON, M.D., M.P.H.
Secretary

Results of Medicare Record Review

From the review of the medical records, we note that the majority of these patients had chronic diseases of the heart or lungs. These were also elderly patients with multiple system diseases and numerous admissions. HCFA data are not, in themselves, measures of hospital performance. This data can be used to better focus quality assurance activities.

LALLIE KEMP REGIONAL MEDICAL CENTER

Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	1		1	
CE -- Cerebrovascular Accidents				
GC -- Gastrointestinal Catastrophes				
GI -- Gastrointestinal Disease		3	2	1
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease		2	1	1
HM -- Severe Chronic Heart Disease	1	3	2	2
HS -- Severe Acute Heart Disease	3	2	5	
ME -- Metabolic/Electrolyte Distur.				
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease	3	2	3	2
RN -- Renal Disease	1		1	
SE -- Sepsis	2		2	
TR -- Severe Trauma				
OP -- Ophthalmalogic Disease				
UN -- Other Diagnoses	2	3	3	2
TOTAL -- All Categories	13	15	20	8

LALLIE KEMP REGIONAL MEDICAL CENTER

Data Verification

Hospital ID Number = 190010

Patient ID Number (HIC)	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death
[redacted]	[redacted]	CA	92	F	1-7-86	1-24-86	1-24-86
		GI	83	F	5-31-86	6-11-86	6-11-86
		GI	70	M	11-8-86	11-16-86	none
		GI	89	M	5-6-86	5-8-86	5-8-86
		HL	75	F	11-21-86	11-28-86	none
		HL	95	F	8-30-86	9-2-86	9-2-86
		HM	81	F	3-11-86	3-19-86	3-20-86
		HM	92	F	4-17-86	4-20-86	4-20-86
		HM	76	M	1-30-86	2-25-86	2-25-86
		HS	62	F	12-12-86	12-20-86	12-20-86
		HS	75	M	10-28-86	11-1-86	11-1-86
		HS	85	M	5-4-86	5-5-86	5-5-86
		HS	94	F	3-27-86	4-3-86	4-3-86
		HS	68	M	12-23-86	12-25-86	12-25-86
		PN	73	M	4-3-86	4-10-86	4-10-86
		PN	61	M	3-24-86	4-4-86	none
		PN	76	M	9-20-86	9-24-86	9-24-86
		PN	68	M	11-15-86	11-18-86	11-18-86
		PN	72	M	11-18-86	11-24-86	none
		RN	88	M	9-24-86	10-10-86	10-10-86
		SE	67	F	9-11-86	9-18-86	9-18-86
		SE	80	M	11-1-86	11-6-86	11-6-86
		UN	65	F	9-2-86	9-3-86	9-3-86

LALLIE KEMP REGIONAL MEDICAL CENTER
Data Verification
Hospital ID Number = 190010

Patient ID Number (HIC)	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death
[redacted]	[redacted]	UN	79	F	9-27-86	9-30-86	9-30-86
		UN	66	M	8-3-86	8-4-86	8-4-86
		UN	73	M	4-14-86	4-22-86	none
		UN	67	M	10-1-86	10-6-86	10-30-86

LA 81.4

*Denotes change in date of death

LANE MEMORIAL HOSPITAL

6300 MAIN STREET
ZACHARY, LOUISIANA 70791
504-654-4511

CHARLIE L. MASSEY
Administrator
DOROTHY N. BARKLEY, R.N.
Assistant Administrator
MARK A. SPANGLER
Assistant Administrator

COMMISSIONERS
JOHN O. LeTARD
Chairman
NICK F. ADAMS
WILLIE BOWMAN
BRYAN W. BRABSTON, JR.
RANDY M. BURRIS

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Medicare Provider Number: 190020

Dear Dr. Roper:

Thank you for the opportunity to review and comment on the HCFA mortality data relating to Medicare patients treated in our hospital in 1986. We are pleased that our comments will accompany the raw statistics in this year's release of mortality data.

Lane Memorial Hospital is a 107 bed, JCAH accreditated, acute care facility which prides itself on providing the highest level of overall quality care to our patients. Lane Memorial Hospital strives to maintain quality care.

The data on mortality rates has been verified by the Medical Record Department and DRG Coordinator and they have found that with minor exceptions that the information is accurate. See attached worksheet and please consider the following comments.

The 1986 data used by HCFA indicates that out of 805 Medicare admissions, 85 patients died in the hospital and 24 died after discharge for a total of 109 deaths. Our statistics indicate that out of 1,105 admissions, 82 patients died in the hospital and 26 died after discharge for a total of 108 deaths. (HCFA included in their data one patient that was never admitted to this facility, hence the difference in the total deaths.)

It does not appear equitable nor statistically valid to include in the statistics 26 individuals who died outside the hospital within 30 days of admission. These individuals could have died from something totally unrelated to their hospitalization. A shorter time span, perhaps 7 days, would be more appropriate for these purposes.

The discrepancy in the total admissions is due to the fact that HCFA counts individual patients and not admissions. The same individual could be admitted several times over the course of a year. If the mortality rate was calculated on admissions rather than patients the rate would be different and would be a better indicator. All of these factors would give a very different mortality rate and possibly a truer indication of mortality.

Our medical staff, through the Medical Record Committee, reviews every mortality at our facility to assess appropriateness, quality of care and to insure continuous high quality care standards. Our Quality Assurance Department provides the hospital and medical staff with data for all areas of patient care.

We feel there are limitations to interpretations of this mortality data as it may not be a true reflection of mortalities. Some factors to be considered are:

1. The data released is based on billing claims submitted by the hospital to Medicare for payment. The clinical (medical) information contained on this billing claim is limited by the form design and coding system used. Mortality rates do not explain why a patient died.

2. The data does not take into account the severity of the individual patient's injury or illness.

3. Patients may have more than one medical problem. Death may be attributed to the secondary (other) diagnosis rather than the principal (cause for admission) diagnosis which is not reflected in the data.

4. Multiple medical/surgical complications also affect the outcome of treatment received by the patient.

5. The age of the patient is an important factor to be considered.

6. Where the patient came from prior to admission, i.e. emergency room, nursing home, etc., is another factor that needs to be considered. Several large nursing homes are in the hospital service area and Lane Memorial Hospital provides hospital service to most of their residents.

7. Certain hospitals generally treat more seriously ill patients than other hospitals.

8. The data may be misleading if there are only a small number of patients in a particular DRG.

9. The information gathered by the PRO applies only to Medicare patients, which is not representative of the entire hospital patient population.

Given the complicated medical nature of this information, may I suggest that news media coverage of Medicare DRG comparisons include statements of caution in interpretation of the data.

Thank you again for the opportunity to respond to this data.

Sincerely,

Charlie L. Massey
Administrator

CLM:bsr

Enclosure

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	9	4	9	4
CE -- Cerebrovascular Accidents	5	2	5	2
GC -- Gastrointestinal Catastrophes	0	0	0	0
GI -- Gastrointestinal Disease	2	2	2	2
GU -- Urologic Disease	7	1	7	1
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	0	0	0	0
HM -- Severe Chronic Heart Disease	8	2	6	3
HS -- Severe Acute Heart Disease	13	2	13	2
ME -- Metabolic/Electrolyte Disturbances	6	0	6	0
OP -- Orthopedic Disorders	0	0	0	0
PN -- Pulmonary Disease	17	3	16	4
RN -- Renal Disease	2	1	2	1
SE -- Sepsis	4	2	4	2
TR -- Severe Trauma	3	0	3	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	9	5	9	5
Total -- All Categories	85	24	82	26
	109		108	

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

LINCOLN GENERAL HOSPITAL
North Central Louisiana's Regional Medical Facility

October 22, 1987

William L. Roper, M.D.
Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Doctor Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for 1986. Since receiving the report, Lincoln General Hospital staff has had an opportunity to assess the data.

Lincoln General Hospital is a 158 bed acute care rural referral facility whose case mix includes many patients with major medical and surgical illnesses. We are a full-service regional center whose medical staff specialities include Pediatrics, OB-GYN, Orthopedics, Cardiology, Pulmonary, and Rehabilitative Medicine as well as General Medicine and Surgery.

Our hospital medical staff committees monitor every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

The hospital specific mortality data reported by HFCA has been reviewed by:
- Hospital Administration
- President of the Medical Staff
- Physician Chairman of the Utilization Review Committee
- Director of Medical Information Services (Medical Records, Quality Assurance, and Utilization Review) and validated data.

As a rural referral center with speciality services provided by Lincoln General that are not provided by other area facilities, complicated, complex, high risk cases are treated by this institution. This statement is substantiated by the case mix of the population and the actual mortality rate of categories as cardiac, pulmonary, etc.

Lincoln General Hospital administration, hospital and medical staff are firmly committed to rendering the highest quality care possible.

Thank you for this opportunity to respond.

Sincerely,

Ronald K. Rooney
Administrator .

J. R. McWhorter, M.D.
President of Medical Staff

csn

MEDICARE PROVIDER NO. 19-0098

SCHOOL OF
MEDICINE IN SHREVEPORT
Louisiana State University
Medical Center
University Hospital
1501 Kings Highway
Post Office Box 33932
Shreveport, LA 71130-3932
Telephone: (318) 674-5060

Hospital Administration

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Thank you for the opportunity to comment on the 1986 HCFA hospital mortality statistics for Medicare patients.

Louisiana State University Medical Center in Shreveport includes both the LSU School of Medicine and its teaching hospital, Louisiana State University Hospital. The University Hospital is a licensed 650 bed acute care referral medical center that is fully accredited by the Joint Commission on Accreditation of Hospitals. We conduct 17 approved residency programs and support the training of 280 house officers and fellows. Clinical Faculty Chairmen of the School of Medicine are chiefs of corresponding clinical services in the University Hospital and with other full time and part-time faculty members, provide the expertise for and direction of patient care programs. A number of programs at the University Hospital, including the region's only burn center, offer Louisiana residents medical care not available in other locations within the State. Because we are a full service medical center with five intensive care units and offer care in many specialty areas such as open-heart surgery, kidney dialysis, organ transplantation, trauma management, and neurosurgery, the University Hospital's Medicare case mix index is one of the highest in the state.

The L.S.U. Medical Center Medical Staff conducts an intensive review of the care rendered to all patients who expire in the institution. This on-going review process forms one part of a hospital-wide Quality Assurance Program designed to monitor and evaluate the quality and appropriateness of health care services. The objective, systematic evaluation of criteria, process and outcome allows us to recognize opportunities to improve patient care and to measure our progress toward that goal.

The HCFA mortality data were reviewed by a team that included members from the Medical Staff, Administration, and ancillary departments. This review has validated that, with minor exceptions, the data are accurate. Although the number of patients who expired after discharge could not be verified, patients included in the report were found to have been hospitalized at L.S.U. Medical Center during 1986.

The following comments are considered relevant:

A number of factors related to a hospital's patient population impact upon its mortality rate. Large, public, teaching hospitals which serve as referral centers for other less-sophisticated hospitals will most certainly treat a disproportionately large number of critically ill patients. More than one third of all LSUMC patients listed in the 1986 HCFA study resided outside the Shreveport-Bossier area naturally served by the hospital. It is further noted that of all deaths reported, twenty-five percent occurred within forty-eight hours following admission, further indicating the critical nature of illness managed in this center. Additionally, many of our elderly patients are at the bottom of the socio-economic ladder. Many of those persons are the victims of their environment in that personal health care is almost non-existent and they often fail to seek medical aid until they are in extremis.

A second influence upon a hospital's mortality rate is the availability of hospice facilities to the population. In 1986 only one very limited hospice program existed in the area. Therefore, many patients suffering terminal illness who could not be managed in the home had no place other than the hospital to serve their needs during the final days of their lives. This represents admittedly less than desirable use of tertiary care center beds, but ethical and moral obligations must be accepted.

The third element which contributes to higher mortality rates is the presence of high quality Emergency Care and Trauma facilities. LSUMC alone receives substantially more patient transports from the area Emergency Medical Service than the other two largest hospitals combined. Burn Center, end-stage renal disease care, the trauma center, transplantation program, and a large modern cardiology service all bring more critically ill patients to our center.

Finally, one should always be concerned about quality. Mortality rate is not, by itself, a measure of the presence or absence of quality but is an indicator which should never be ignored in determining whether a quality issue exists. A mortality review of every case is conducted by faculty and house staff of the service attending the patient at the time of death. A second level review of a selected number of cases is conducted by the Quality Assurance Committee, and a generic screen of all records is routinely conducted in the hospital against approved criteria for each service. These are a major part of a very strong Quality Assurance Program. In those cases reported by the HCFA study, faculty physicians of the Quality Assurance Committee and the Utilization Review Committee with representatives of management and ancillary services again reviewed the records. We conclude that the quality of care delivered in those cases is well within any standard of excellence one might use and, indeed, is a reason why our hospital mortality rate is as low as reported. Normally, given the patient population served and the critical-care referral environment of the institution, one would predict a significantly higher rate than was experienced.

Sincerely,

Gene L. Hammett
Hospital Administrator

cnj

MERCY HOSPITAL•NEW ORLEANS

An Affiliate of Mercy Health System of the Gulf South

October 28, 1987

Mr. Brooks
Health Standard and Quality Bureau
Room 2-D-2
Meadows East Building
6300 Security Blvd.
Baltimore, Maryland 21207

RE: Mortality Rates
Mercy Hospital of New Orleans
Medicare Provider # 190075

Dear Mr. Brooks:

Thank you for this opportunity to respond to the release of data by the Health Care Financing Administration on Hospital Mortality Rates.

Mercy Hospital in New Orleans is a 275 bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full service hospital offering care in specialty areas of oncology, major orthopedic services, cardiac rehabilitation services, as well as, general medicine and surgery. As part of a comprehensive health delivery system, Mercy also supports a Skilled Nursing Facility, Home Health Service, and Adult Day Care. We have a high percentage of elderly patients with multiple medical conditions.

The Hospital took a very serious look at the mortality data to be released. We were pleased to note that our death rate was within the predicted range for all areas. An in depth chart review was conducted in the following areas:

1. Cerebrovascular Accident (stroke)- 14 of 15 deaths occurred in cases in which the patient and/or family had requested "no code".
2. Severe Chronic Heart Disease (Heart Failure)-15 of the 30 deaths were patients who had requested or whose family had requested, do not resusitate. Nine patients were discharge from the Hospital alive, but had multiple conditions (for example: cancer, extensive heart disease).
3. Gastrointestinal Disease-8 of the 9 deaths were cases in which the patient and/or family had requested "no code".

301 N. JEFFERSON DAVIS PARKWAY ° NEW ORLEANS, LOUISIANA 70119 ° (504) 486-7361

Our present Quality Review system includes mortality review by each Medical Staff Department. This is an on-going process that also includes trending analysis in a constant endeavor to assist in identifying opportunities to improve care. Peer review activities are an integral part of the monitoring of the health care delivery system at Mercy.

Should anyone reviewing this information have any questions, please do not hesitate to call.

Sincerely,

Sister Barbara Grant

Sister Barbara Grant, R.S.M.,
Chief Executive Officer

SBG:lmj
0534F

The closest thing to home.

MINDEN
MEDICAL CENTER

October 26, 1987

William L. Roper, M.D., Administrator
Healthcare Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics compiled by your organization prior to their scheduled release in December. The following information is to be attached to the Hospital Specific Report for our facility.

Minden Medical Center is a 108 bed general acute care facility. In addition to 66 medical/surgical beds, we also staff a 6 bed intensive care unit, a 16 bed skilled nursing facility and a 20 bed chemical dependency unit.

On an ongoing basis, our Medical Staff committees review each death to assure that the quality and appropriateness of care delivered at our facility consistently meets or exceeds state and national standards. Mortality review is an integral part of our hospital-wide quality assurance program and peer review is a very important part of the monitoring of the healthcare delivery system at this facility. No problems have been identified with this process either by a recent survey by the Joint Commission on Accreditation of Hospitals or by the ongoing review by our state Peer Review Organization.

Our Director of Medical Records has carefully analyzed your results and, with minor exceptions, has verified them. These results have also been discussed with members of our Medical Staff and will be a useful tool in our ongoing peer review process.

Thank you again for the opportunity to present this response.

Sincerely,

George E. French, III
Administrator

GEF:slc

MOOSA
MEMORIAL
HOSPITAL

P. O. Box 1026
Eunice, Louisiana 70535
Phone (318) 457-5244

Douglas C. Longman,
Administrator

October 13, 1987

Dear Dr. Roper,

Thank you for the opportunity to respond to HCFA Mortality Data release for 1986. Since receiving the report Moosa Memorial Hospital's staff has had an opportunity to review the data.

Moosa Memorial Hospital is a 92 bed acute care medical and surgical facility.

The Director of Medical Records has validated that, with two exceptions (one case with wrong date of death and one with wrong discharge date) the data is accurate. Our hospital mortality report was reviewed by: the hospital administrator, the Chief of Staff, Chairman of the Utilization Review and Quality Assurance Committees and the Director of Medical Records.

The Medical Staff at Moosa Memorial reviews all mortality cases for quality and appropriateness of care rendered to each patient on an on-going basis.

It should be noted that 33% of the patients (14) were placed on "No Code" by request of the family; 42% of the patients (18) expired on the day of admission or the following day despite aggressive medical treatment; and the average age of the patient was 76 years. Moosa Memorial's actual mortality rate for each diagnostic category fell in the range of the predicted mortality rates.

Thank you for the opportunity to present this response.

Sincerely,

Douglas C. Longman

Douglas C. Longman
Administrator

DCL:jm

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

NORTH CADDO HOSPITAL SERVICE DISTRICT
1000 South Spruce Street
VIVIAN, LOUISIANA 71082

October 23, 1987

NORTH CADDO MEMORIAL HOSPITAL
1000 South Spruce Street

RONDY HARTLINE
Administrator

HOSPITAL PROVIDER NO. 190071

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Thank you for this opportunity to respond to the release of data on hospital mortality rates for the period January 1, 1986 through December 31, 1986. The following information should be attached to the Hospital Specific Report prior to public disclosure.

North Caddo Memorial Hospital is a 33 bed acute care facility, whose casemix includes many patients with multiple medical illnesses. We run approximately 70% Medicare with the average of our mortality cases being 84 years old.

The hospital's specific mortality data reported by HCFA has been carefully reviewed by the Medical Staff, Management, and the Quality Assurance Committee. The percentages of every category fall within the predicted ranges with the exception of the category Severe Acute Heart Disease. The following should be noted concerning this category.

* The average age of this category was 80 years old.
* Seven of the eight patients had a previous history of heart disease.
* One of the patients was placed on "do not resuscitate" by request.
* Two patients had terminal metastatic disease.

North Caddo Memorial Hospital is committed to providing the highest quality care as evidenced by its on-going Quality Assurance Program and full Accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

As an on-going process of our Quality Assurance program, the Medical Staff at our facility conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care.

It is important that any reviewer understand that to measure quality of care requires looking at many variables and quality indicators. Mortality is only one of these quality indicators.

Again, thank you for allowing us the opportunity to present this response.

Sincerely,

John H. Haynes, M.D.
Chief of Staff

Rondy Hartline
Administrator

North Claiborne Hospital
Service District 1

Highway 79 South
Post Office Box 431
Haynesville, Louisiana 71038

October 26, 1987

William A. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

This is North Claiborne Hospital's comment (Provider Number 19-0132) in response to the Health Care Financing Administration's mortality infomation on Medicare patients treated in 1986 at our facility, which is intended for public release in December.

North Claiborne Hospital is a 32-bed general, acute care hospital located in Haynesville, Louisiana, a rural community of approximately 4000 population in North Central Louisiana. The facility operates as a hospital service district having served its community since 1969.

A review of the mortality information for North Claiborne Hosptial as sent to us reflects that the actual mortality rate as determined by the study falls well within the study's range of predicted mortality rates for each diagnostic catagory at our facility.

With regard to standards of care and the possible erroneous implications of this data release, it should be noted that an essential element of our hospital's operation is its on-going quality assurance program in which the broadest range of patient care activities and hospital functions are closely scrutinized on a regular basis. Also, every case in which death occurred is reviewed for quality and for appropriateness of care.

These review programs and the general hospital operation have met and continue to meet the requirements for participation in the Medicare program and are indictive of the maintenance of quality patient care offered by the hosptial.

Despite the satisfactory results portrayed by the study regarding patients treated at North Claiborne Hospital, it should be emphasized that we do not consider mortality rates as an appropriate assessment of an institution's quality of care. Since the study, among other things, deals only with the Medicare patient population, does not account for the severity of the patient's condition, and by inevitable consequence, deals with an elderly patient group, the publishing of this study with all its limitations could be very misleading to the public.

Consequently, if such release is inevitable, we strongly urge that full disclosure of the study's limitations be provided with the public release of this information, and that the inappropriateness of attempting to use it as a measure of quality of care be forcefully emphasized with the release.

Through its utilization review and quality assurance programs, North Claiborne Hospital is committed to high quality patient care and will continue this committment to meet the future best interests of its patients.

Thank you for the opportunity to respond.

Sincerely,

Stan Williamson
Administrator

SW/jm

NorthShore REGIONAL MEDICAL CENTER
A National Medical Enterprises Health Care Facility
100 MEDICAL CENTER DRIVE • SLIDELL, LOUISIANA 70461-8572
TELEPHONE: 504-649-7070

October 22, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau - Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you very much for allowing NorthShore Regional Medical Center this opportunity to respond to the data release on mortality rates for 1986.

NorthShore Regional Medical Center is a 150 bed acute care facility located in Slidell, Louisiana. Our facility provides a wide range of medical and surgical services to our service area. Most notable of these services include cardiology (including cardiac angiography and surgery), orthopedic surgery, neurosurgery, and obstetrics. Since this facility was initially opened in June of 1985, we have continually sought to identify the health care needs of our local community and to provide high quality services to meet these needs.

The Medical Staff of NorthShore Regional Medical Center conducts a comprehensive and ongoing quality assurance and utilization management program. The objective of these efforts is to insure that every patient receives a consistently high standard of medical care. One of many parts of this program is to evaluate and thoroughly review every individual patient, including those who expire at this facility. This is an ongoing program to insure that high quality standards are maintained at all times.

The 1986 mortality data for NorthShore Regional Medical Center has been carefully reviewed by our Quality Assurance/Utilization Review Department and our physician Medical Director, who oversees these functions. Although the actual mortality data for each of the diagnostic categories was within the HCFA expected ranges for these categories, our staff has conducted an analysis of this data for the purpose of supplementing our ongoing quality assurance function. Some of the more significant findings of our staff are as follows:

1. The average age of these patients was high (78.5 years).
2. A high percentage (62%) of these patients were diagnosed by their physicians and one other physician as having a terminal and irreversible condition ("no code").

3. An extremely high percentage (93%) of these patients were diagnosed as having major multi-system diseases.

Our analysis of the mortality data has provided us with another tool to continually assure that we are providing quality health care services to our patients. As we previously discussed, our facility monitors the quality of care provided to each patient on an individual basis. We feel that evaluation of mortality data without a consideration of a wide variety of other factors which are particular to a specific patient does not give a valid indicator of health care quality. With this in mind, our Medical Staff will continue to perform a thorough and comprehensive review of every patient on an ongoing basis.

Again, on behalf of NorthShore Regional Medical Center and its Medical Staff, we would like to thank you for allowing us to comment on this very important issue.

Sincerely yours,

Kirk R. Wascom
Executive Director

Aydin Onel, M.D., Dr.P.H.
Chief of Medicine
Medical Director - Quality Assurance/Utilization Review

/kl

OCHSNER FOUNDATION HOSPITAL
Alton Ochsner Medical Foundation
1516 Jefferson Highway
New Orleans, Louisiana 70121
Phone: 504/838-3000

October 22, 1987

Ochsner

Medicare Provider
#19-0036

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Ochsner Foundation Hospital appreciates the opportunity to comment on the mortality statistics, which have been released by the Health Care Financing Administration (HCFA). Ochsner endorses the principle of providing the public with objective information about the quality of medical care. We consider this practice to be consistent with the reputation for quality, which has characterized Ochsner for many years. The objective of our response is to elaborate upon the work done by HCFA by describing more fully the nature and characteristics of groups of Ochsner patients reported on in the study.

The Health Care Financing Administration furnished Ochsner with a list of 383 Medicare patients, who died within 30 days of having been hospitalized at Ochsner. A thorough review of each case revealed that six of these patients had not received their care at Ochsner and an additional patient was placed improperly by HCFA in the low risk cardiac category instead of the high risk category. HCFA has been advised of these findings. Review of the data also validated that the remaining deaths reported did occur. Of the 56 patients who died within 30 days after discharge from Ochsner, 44% were known to have had terminal cancer.

We consider the issue of acuity to be quite relevant to mortality statistics. The term acuity is recognized generally to mean severity or degree of illness. HCFA has defined an acuity index of 1.0 as the average acuity of illness for all Medicare patients. Any acuity figure greater than 1.0 means that patient, or group of patients, is more seriously ill than the average Medicare patient. In fact, the data indicate that Ochsner's Medicare patients, as a group, at 1.3985, have the highest acuity index in the State of Louisiana.

Of the seventeen categories studied by HCFA, Ochsner was within the predicted mortality range in 16 categories and was in the lower one third of the predicted range in 12 of the categories.

Ochsner's 10% overall Medicare mortality was at the lower third of the range predicted by HCFA. This performance is particularly significant, given our reputation as a regional referral center for patients with very complicated illnesses requiring complex diagnostic and treatment capabilities. For the group of patients who died, the acuity index was even higher; almost two thirds of the Medicare patients who died were in their 70's and one third were 76 or older. More than half of the patients who died were admitted to Ochsner by way of the Emergency Room or had been transferred here from another health care provider.

The only category in which Ochsner exceeded the predicted mortality range was Low Risk Heart Disease, where we measured 9%, versus a predicted 3-7%. We have calculated that the patients in this category who died had an acuity index of 3.6828, representing a severity of illness two and one half times greater than that of the average Medicare patient. We believe it is significant that 69% of this group had one or more underlying cardiac conditions which would have been classified in the high risk cardiac category, had that condition been the reason for their admission to the hospital. Moreover, 31% had a significant, noncardiac, underlying condition, such as kidney failure or pulmonary disease, in addition to their main reason for admission to the hospital. During their stay at Ochsner, 55% of these patients had major cardiac surgical procedures and one third were admitted through the Emergency Department or transferred from another health care provider. Nearly two thirds of the 45 deaths in this category involved patients in their 70's, while more than one third were seventy-six or older.

Although Ochsner Foundation Hospital was within the ranges predicted by HCFA in all of the remaining illness categories, these groups of patients shared many of the same characteristics discussed previously. Ochsner Medicare patients included in the HCFA study tended to exhibit very high levels of acuity and our physicians often had to manage their principal illnesses in the presence of at least one and sometimes multiple, underlying serious conditions. The extent to which Ochsner Medicare patients were admitted through the Emergency Department, or transferred from other facilities, adds emphasis to the contention that an institution with an established reputation as a referral center faces an unusually significant challenge in caring for elderly patients.

Like most other hospitals, Ochsner's first experience with the widespread public disclosure of this type of data is the HCFA mortality data release. However, Ochsner considers itself unique for having developed effective internal systems, which enable us to scrutinize and assess the quality and appropriateness of the care we deliver. These assessments occur during a patient's stay and continue after discharge.

Moreover, they apply to all patients and are not limited to Medicare or any other selected group of patients. We consider our approach to quality to be affirmative and we view Ochsner as a leader in this area. The HCFA mortality information has been reviewed thoroughly by our medical and administrative staffs. The results already have been integrated into our existing quality assessment systems, to enhance them further.

Sincerely yours,

David R. Page
Executive Vice President and
Hospital Director

Edward S. Connolly, M.D.
President, Medical Staff

MEDICARE PROVIDER - 190102

October 20, 1987

HEALTH CARE FINANCING ADMINISTRATION
HEALTH STANDARDS & QUALITY BUREAU
HOSPITAL MORTALITY INFORMATION
PO BOX 26684
BALTIMORE MD 21207

INFORMATION TO BE ATTACHED TO HOSPITAL SPECIFIC REPORT

The following information for Our Lady of Lourdes Regional Medical Center is to be attached to the Hospital Specific Report for the period January 1, 1986, through December 31, 1986, prior to public disclosure.

Our Lady of Lourdes Regional Medical Center, located in Lafayette, Louisiana, is a licensed 397-bed medical complex serving an eight parish area known as Acadiana. We are a full-service medical center, offering care in specialty areas of oncology, open-heart surgery, orthopedic services, neurosurgery, and rehabilitative medicine, as well as general medicine and surgery.

The Medical Affairs Division of Our Lady of Lourdes is headed by a physician who works to further enhance rapport and relations between the medical community and the Center's staff. The division has responsibility for the operation of the affairs of approximately 300 members of the medical/dental staff, in all its aspects, to assure that quality patient care and services are provided. All major specialties are respresented by the staff members, allowing for prompt and efficient referrals.

The medical staff of Our Lady of Lourdes conducts an intensive review of the medical record of every patient who expires at this facility, regarding medical management and overall care. Mortality review is an ongoing process of the quality assurance program, and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrator, the medical director, the president of the medical staff, the physician chairman of the medical care evaluation/utilization review committee, the director of quality

assurance, and the director of medical records. Based on the comprehensive review of the data and the specific medical records it reflects, we are confident that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

As previously stated, review by this facility is always by individual case with reference to quality of care, and is conducted in an ongoing fashion, not just when statistics such as the mortality data are released.

We would like to thank you for the opportunity to present this response.

DUDLEY ROMERO
PRESIDENT & CEO

KENNETH EARLE, M.D.
MEDICAL DIRECTOR

DL/jos

OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER

October 21, 1987

William L. Roper, M.D.
Administrator,
Health Care Financing Administration
Dept. of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the selected mortality information, pertaining to Medicare patients treated between January 1st and December 31st, 1986, which your agency will release. Since receiving the information, the staff of Our Lady of the Lake has had an opportunity to review the data and feel the need to comment on the accuracy, context and application of this data.

Our review of the data identified some inaccuracies, such as coding errors, discrepancies in significant dates and inaccurate recording of patient diagnosis. Given the public dissemination of this information, we are very concerned that this release, and subsequent releases, use data which has been diligently verified for everyone's sake. We commit ourselves to fulfilling our role in making certain that the data can, and does, provide an accurate basis for further use.

Like all information, the mortality data must be viewed in an appropriate context. Specifically, the consideration of mortality rates is anything but a simplistic exercise. As presented, this mortality data is simplistic. To begin with, the information from which the actual rates and predicted ranges were calculated is billing information. Just as any invoice or receipt provides limited descriptive information, so too the billing information used by the Health Care Financing Administration (H.C.F.A.) is extremely limited in its ability to consider the patient's condition before, during or after care. Other limits of the H.C.F.A. include:

- Presenting mortality rates without factoring the severity of the patient's condition,

- basing the diagnostic categories on the principal reason for the patient's admission, instead of the true "cause of death",

5000 Hennessy Boulevard Baton Rouge, Louisiana 70809 (504) 765-6565

ascribing mortality outcomes to hospitals without verifying that the true "cause of death" was at all related to the care rendered to the hospital, and

not considering whether the patients treated suffered from a terminal illness, making death an expected, and perhaps imminent, outcome.

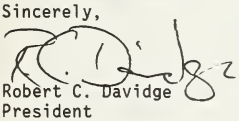
Our Lady of the Lake Regional Medical Center offers a wide range of patient care services. Given the breadth of patient care services, Our Lady of the Lake serves as a regional referral center, offering specialty care to patients with cancer, heart disease, trauma, as well as general medical and surgical needs. Our distinction as a regional referral center establishes a situation whereby we receive a significant number of patients from outlying hospitals who are critically ill and/or have a poor prognosis.

The data you have provided us will be incorporated into Our Lady of the Lake's ongoing review of mortality cases. The ongoing review of mortality cases is an activity which the physicians and hospital conduct in order to professionally monitor the care provided to our patients.

Finally, we at Our Lady of the Lake feel that the H.C.F.A. release of mortality information is an unrefined example of data intended for an honorable use. Perhaps you yourself said it best when you stated, "The information on its own is not a complete measure of quality of care at an individual hospital. While we (H.C.F.A.) believe that the information on mortality rates is useful, until we (H.C.F.A) have developed additional, statistical measures to deal with complex issues such as severity of illness, we cannot and do not recommend the use of this information by itself to make judgments about the quality of care in an individual hospital, or to make comparisons among hospitals."

Because the choice of selecting the best health care available involves many factors, we at Our Lady of the Lake offer the above comments, and look forward to working with the Baton Rouge community, and H.C.F.A., to provide meaningful information on which informed decisions can be made.

Sincerely,



Robert C. Davidge
President

/dp

PENDLETON MEMORIAL
METHODIST
HOSPITAL

Courtesy
Concern
Kindness
Compassion

October 15, 1987

Mr. William Roper, M.D.
Health Care Financing Administration (HCFA)
Washington, D.C. 20201

Re: PROVIDER #190124 - Mortality Data

Dear Dr. Roper:

This letter is in response to the mortality data relative to Medicare patients treated at Pendleton Memorial Methodist Hospital (PMMH) during calendar year 1986. The following comments address three key issues of significant concern raised by this report. First the validity of data, second those characteristics unique to PMMH, and third the assumption that a mortality rate/ratio can be an effective measure of the quality of care that a hospital delivers to its patients. Clearly, we question the strength of association between HCFA's definition of a hospital's mortality rate by diagnostic category and the quality of care and treatment a patient receives.

The data used by HCFA indicated that a total of 1463 Medicare patients admitted to PMMH died within 30 days of admission. Our records indicate that of the 1463 Medicare patients who died within 30 days of admission while still an inpatient, 25 were alive at the time of discharge (not "in-hospital" deaths) and 10 patients expired on the same day of admission. To accurately reflect actual deaths these numbers should be subtracted from total deaths. In both instances the numerator is reduced. As a result of the inclusion of these patients we feel our death rates have been over stated.

We are concerned with the data itself because the results revolve around death rates that include deaths which occurred after hospital discharge. While this adjustment was made to reflect differences in availability of post hospital extended services, a new bias is introduced, which is the number of deaths which occurred that are unrelated to the condition of the patient reported by HCFA and occurred in the patient's home or in a post acute care facility. We do not feel it is appropriate to hold a hospital accountable or responsibile for medical care given by other facilities. A 30 day time frame is too long and will overstate the rate and produce misleading results for patients who were hospitalized for a brief period, and died past their hospital stay (for example 28 days after discharge from hospital).

The following is a brief description of the patient population PMMH serves and selected specific services which PMMH offers which were not adjusted for in the HCFA model calculations. PMMH is a full service, 317 bed acute care facility with a full compliment of medical and surgical services as well as a Oncology Unit and Neonatal Intensive Care Unit. In addition to being accredited by JCAH, PMMH conducts a Quality Assurance program whose purpose is to enhance patient care through on going objective assessments of patient care. PMMH's primary goal has been to provide quality patient care to the residents of the New Orleans community. The PMMH Quality Assurance program is structured to undertake studies which analyze and assess various patient care problems. Qualified physicians, hospital personnel and administrators using established clinical care criteria, conduct these studies whose outcomes are designed to achieve an effective level of quality patient care.

The primary service area of PMMH is New Orleans East. This community consists of a significant number of elderly, above age 65, residents who are Medicare beneficiaries. Methodist Hospital plays a key role in serving elderly patients in this community. Moreover, Methodist Hospital is a unique provider in New Orleans because of the significant number of transfers we receive from area long term care facilities and nursing homes. Often these patients are transferred to us with existing chronic and degenerative diseases. Some of these patients are transferred to PMMH in their last few days of life. From our point of view it is impossible to attest accurately to the quality of care and treatment the patient receives prior to transfer. The point is that PMMH receives and treats patients from other facilities, namely nursing homes that traditionally treat chronically ill and terminally ill patients. PMMH also provides short term skilled nursing care through our 15 bed Skilled Nursing Unit. This unit bridges the gap, for the patients who no longer need the intense level of acute care services and in some cases awaiting transfer to a long term skilled nursing facility. In summary PMMH serves as a key referral center for nursing home patients.

The question HCFA is trying to address: What is the actual death rate for PMMH compared to what would have been expected given PMMH's characteristics are filled with some inherent complexities relative to how to predict patient outcome. A mortality rate alone is in and of itself a very rough measurement because other factors contribute to patient outcome (such as severity of illness, family history and other risk factors).

We feel that a mortality rate cannot be used as a single measure of the level of quality care and treatment a patient receives. Given this, the impact on publication of this mortality data alone, without substantial public education will be misleading for consumers, and unfair to hospitals.

Although PMMH is not opposed to this type of analysis, we are sensitive to the manner in which it will be presented and published to the public. The public has a right to know and understand fully, that even within a diagnostic category, many factors contribute to patient outcome.

As a concluding note we would like to emphasize to the public, that it is necessary to evaluate carefully the comparability of the Medicare patients and expected patient outcome with respect to the unique qualities of PMMH and the Medicare patients it serves. We offer the following recommendations:

1. Shorten the time period considered after discharge. 7 days instead of 30 days.

2. Mortality rates should be made more specific to identify sub-groups by dividing the Medicare patients into sub-groups by age.

3. Adjust each hospital's mortality ratio individually by severity of illness and case mix characteristics.

4. Medicare data should be published separately and not formatted to compare one hospital's experience to another.

5. Include other risk factors such as smoking in HCFA calculations and analysis.

6. Responsible publication of the medicare data, with a full explanation of its meaning and limitations.

7. Provide further explanation and delineation of the comorbidity recognized in the HCFA Mortality rate calculations to generate the rates in "Range of Predicted Mortality."

If there are any questions or you would like further information please do not hesitate to contact me directly. Thank you for the opportunity to comment.

Sincerely,

Fred Young, Jr.
President

FY/dkl

JOHN GREZAFFI
Vice Chairman

CARL McLEMORE, M.D.
Chairman

EDWARD C. NELSON
Secretary

Members:
JAMES BOUANCHAUD
JUNIES HURST
BOBBY FULMER, M.D.

Members:
MARY LENA SNEED
MIX VOSBURG
MAURICE PICARD

POINTE COUPEE PARISH
HEALTH SERVICES DISTRICT I

P.O. Box 578
2202 FALSE RIVER DRIVE
NEW ROADS, LA 70760-0578

October 5, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

In reviewing the mortality rate list that you sent us, we have noticed many errors in this document.

We therefore, by means of this letter, will point out the errors in which we have found. This includes five deaths, which you need to correct the dates. (See attached list). We have one patient that did not die in our hospital, that is on the list. We would appreciate you removing this patient from the list. One patient has the wrong name, we have changed the name in the attached list. We have noticed that there are six deaths that you have not included, which we have included.

There are eight deaths on your list that we have no record of anyone expiring on those given dates or those names. We have reviewed, both our Emergency Room logs and our hospital logs. We would therefore appreciate you removing those from your list. (See attached list).

If there are any questions, please contact us. We thank you for your cooperation in this matter. We hope you will correct these errors that are on this original mortality list, in which you submitted us.

Sincerely,

Jerry Marquette
Adminsitrator

JM/mb
C: Quality Assurance Committee
Louisiana Hospital Association

"AN EQUAL OPPORTUNITY EMPLOYER"

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

9-30-87

Final changes for the 1986 mortality rate listing were:

Changed 5 dates of death to their corrected dates:

From 8-24-86 to 8-26-86
From 10-28-86 to 10-26-86
From 2-10-86 to 2-7-86
From 7-31-86 to 7-30-86
From 8-2-86 to 8-1-86

Removed [redacted] from the listing as they were in our hospital at that time but did not expire.

Changed [redacted] name from [redacted] to [redacted] to match our records.

Added the following cases to the list:

Deleted the following cases from the listing as we had no record of anyone expiring on the given dates. The 1986 ER log was also used as a reference and we had no one to expire on these dates.

HOSPITAL ID NUMBER 190059

Patient ID Number (HIC)	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Death	Principal Diagnosis	Principal Procedure
[redacted]	[redacted]	HM	86	F	12/27/85	01/10/86	428.0	3891
		HS	83	F	12/13/85	01/01/86	410.1	3772
		PN	83	M	12/30/85	02/02/86	493.90	9904
		PN	83	M	04/05/86	04/10/86	482.1	SNF
		PN	88	F	01/09/86	01/12/86	493.90	
		PN	90	M	12/21/86	12/21/86	496	
		PN	91	F	06/26/86	07/09/86	482.0	
		PN	86	F	02/05/86	02/07/86	415.1	
		PN	94	F	03/16/86	03/17/86	482.1	
		PN	91	F	03/25/86	04/02/86	486	SNF
		PN	25	M	09/23/86	09/26/86	5185	
		PN	82	F	04/22/86	04/25/86	482.2	8964
		RN	82	M	05/25/86	05/26/86	585	
		RN	94	M	07/11/86	07/30/86	586	4524
		RN	97	M	10/31/86	11/02/86	586	
		SE	81	M	01/27/86	02/08/86	038.49	
		SE	86	M	05/20/86	05/23/86	038.9	
		SE	79	F	11/24/86	11/28/86	038.1	SNF
		SE	94	F	08/30/86	08/30/86	038.9	
		UN	79	M	08/31/86	08/01/86	9974	5411
		UN	68	M	03/19/86	03/24/86	9721	45.24
		UN	88	M	09/27/86	10/04/86	6951	
		UN	83	M	01/09/86	01/25/86	4660	
		UN	72	M	05/30/86	06/01/86	3229	0331
		UN	84	M	02/10/86	02/11/86	4660	
		CA	67	M	09/09/86	09/13/86	1629	
		CA	68	M	08/21/86	08/26/86	1629	
		CA	78	F	03/29/86	03/31/86	1890	
		CA	65	F	09/27/86	10/07/86	1749	
		CA	81	M	05/16/86	05/18/86	1539	
		CA	63	F	04/04/86	04/27/86	2030	SNF
		CA	46	F	06/11/86	07/02/86	1539	
		CA	85	F	05/02/86	05/06/86	1519	9904
		CE	84	M	10/10/86	10/10/86	436	
		CE	84	M	10/07/86	10/09/86	436	SNF
		CE	92	F	01/05/86	01/22/86	436	5423
		CE	79	F	05/08/86	05/09/86	436	
		GC	83	M	05/04/86	05/25/86	5672	5419
		GC	78	M	07/01/86	07/01/86	5602	
		GC	90	F	08/07/86	08/08/86	5570	5411
		GC	76	F	01/21/86	01/30/86	5672	9904

LA 110.2

HOSPITAL ID NUMBER 190059

Patient ID Number (HIC)	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Death	Principal Diagnosis	Principal Procedure
[redacted]		GC	84	F	09/24/86	10/05/86	5579	
		GI	82	F	06/16/86	07/08/86	5601	
		GI	56	M	03/18/86	03/26/86	5712	
		GI	94	F	06/21/86	06/30/86	5303	431
		HM	77	F	05/11/86	05/15/86	4280	
		HM	71	F	01/11/86	01/16/86	4280	8964
		HM	82	F	10/18/86	10/26/86	4280	3491
		HM	94	F	01/18/86	01/20/86	4280	
		HM	91	F	07/17/86	07/24/86	4280	
		HM	88	F	07/22/86	07/30/86	4280	
		HM	99	F	09/08/86	09/14/86	4280	
		HM	90	F	09/16/86	09/19/86	4280	
		HS	63	M	07/10/86	07/13/86	4105	89.64
		HS	82	M	03/29/86	03/29/86	4101	
		HS	87	M	11/25/86	12/02/86	4107	
		HS	76	M	12/16/86	12/21/86	4107	
		HS	81	F	05/04/86	05/07/86	4109	
		HS	76	F	10/21/86	10/26/86	4107	
		HS	67	M	04/26/86	04/28/86	4105	3491
		HS	69	F	02/12/86	02/12/86	4109	
		HS	79	M	07/13/86	07/18/86	4271	
		HS	82	F	03/26/86	03/27/86	4109	
		HS	70	F	05/30/86	06/01/86	4101	
		ME	71	F	03/05/86	03/07/86	2765	
		ME	85	F	07/12/86	07/12/86	2769	
		PN	83	M	09/29/86	10/05/86	4828	
		PN	71	F	12/04/86	12/07/86	4912	
		HS	73	M	02/22/86	02-24-86	4109	
		CE	81	M	04/23/86	04/24/86	787.2	
		CA	63	F	04/23/86	04/25/89	174.9	
		PN	81	F	06/05/86	06/05/86	415.1	
		GC	70	F	10/03/86	10/17/86	557.0	
		CA	80	M	09/29/86	10/18/86	189.0	

Rapides General Hospital
Box 30101, 211 4th Street
Phone (318) 473-3150
Alexandria, LA 71301-8421

James T. Montgomery
Executive Vice President

October 21, 1987

Dr. William L. Roper
Department of Health and Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Re: 1987 Mortality Data Reply from Rapides General Hospital

Dear Dr. Roper:

Thank you for the opportunity to reply concerning the HCFA mortality data that we received in late September, 1987. This information covered patients admitted to our hospital in the year 1986.

Rapides General Hospital is an acute care facility with 349 beds. General care includes medical, surgical, ICU, emergency, orthopedic, urologic, gynecologic, cancer treatment, chemical dependency, renal dialysis and cardiac care. Cardiac care provides catheterization with diagnostic and therapeutic capabilities as well as an active cardiac surgery unit and rehabilitation program. The Chemical Dependency and Cancer Treatment Centers are free standing.

Our hospital is a major receiving center for referrals from outlying areas. We also give support to multiple nursing homes. Central Louisiana has 113 nursing home beds per 1,000 population, whereas the state average is 85.8 per 1,000 population. This information was secured in January, 1987 according to statistics of September 30, 1986, by the Louisiana Nursing Home Association.

Review of the 1986 Mortality Data was by multiple Medical Staff Members, the Quality Assurance Committee and representatives of Administration. There were fifty records identified as patients having expired within thirty days of discharge from Rapides General Hospital. Our review of those records revealed 9 that were incorrectly assigned to this group. Those 9 included:

(1) 3 patients were transferred to other acute care facilities within the state; and

(2) 6 patients who expired during subsequent readmissions to this facility.

The hospital specific data reported Rapides General to be within the predicted range of mortality rates. Our review generally validates the report except for occasional minor age variations.

An in-depth study was done on Severe Acute Heart Disease which had the highest predicted mortality range. Our findings are as follows:

1. 77.3 average age.
2. 24% were nursing home patients.
3. 9% were referrals from outlying hospitals.
4. 9% were comatose on arrival and remained so until death.
5. 24% had pacemakers inserted or had prior placement for arrhythmia.
6. 12% had previous myocardial infarcts.
7. 9% were the result of major vessel catastrophe (aneurysm rupture).
8. All but one of the 34 deaths had other serious conditions including diabetes, end stage renal problems, severe respiratory problems and cardiogenic shock and dysrhythmia.

We recognize the importance of this date to supplement and verify our on-going death review. Death review in itself is one of many factors in determining outcome data which may reflect quality of care.

Thank you again for this data which we are using in our ongoing Quality Assurance and Utilization Review Program.

Sincerely,

James T. Montgomery

Jim Montgomery
Executive Vice President

C. W. Lowrey, M.D.

C. W. Lowrey, M.D.
Medical Coordinator

RAYNE-BRANCH HOSPITAL
P. O. Box 427
Rayne, Louisiana 70578

October 23, 1987

RE: MORTALITY STATISTICS
January 1, 1986 - December 1986

Thank you for this opportunity to respond to the release of data on hospital mortality rates for the period indicated.

After reviewing the related Mortality Data submitted to our hospital by HCFA we find that in many cases the diagnostic category in which the mortality was reported was not related to the cause of death.

We have attached details of our findings for HCFA's review and due to the coding procedures established, the mortality statistic for any patient dying in the hospital or within thirty days after discharge is grouped with the diagnostic category of the principal admitting diagnosis. In view of this any patient with an underlying medical problem but admitted for another given illness would be grouped with the diagnostic category relating to the principal diagnosis and not the underlying medical problem which caused the death. This is true of our hospital in that we found several cases in which the death was reported in one category but actually related to another, more severe category.

We reclassified several deaths to such categories as Cancer, Stroke, or severe Heart Disease.

We would also like to point out that we had only 44 reportable deaths for the year (in-house--post discharge) of which only 29 were included in the diagnostic category in which the particular cases were grouped. While all mortality rates are well within or below the predicted ranges the small number of cases and related deaths may render the rates statistically invalid.

Our hospital has an on-going process in which the medical staff reviews all death cases in every effort to insure the highest standards of quality care rendered.

Sincerely,

Dale Moore

Dale Moore
Chief Executive Officer

Richland Parish Hospitals

P. O. Box 388
Rayville, Louisiana 71269

507 Cincinnati
Delhi, Louisiana 71232

Provider Number - 190151

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

October 23, 1987

Dear Sirs,

Richland Parish Hospital at Rayville, is a 75 bed acute care facility who treats many patients with major medical and surgical illnesses. We are a full service medical center offering specialty areas in pulmonary medicine, general surgery, orthopaedic surgery, ophthalmology, urology, internal and general medicine.

It should be kept in mind that, according to the Northeast Louisiana University Center for Gerontology, that the national average population for elderly is 12%. The average for elderly in Richland Parish and surrounding parishes that we serve is 20%. It should be further noted that of this number, nearly half live at or near the poverty level. Further, Richland Parish has recently been shown to have a higher incidence of cancer, according to the latest North Louisiana Tumor Registry Report, than any other parish in Northeast Louisiana.

Because of the age, income levels, and general acuity of our average patient, the hospital is extremely pleased to have death levels below those which might be expected.

The medical staff at the hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. The Joint Commission on Accreditation of Health Care Organizations bestowed on this facility its approval of the hospital Quality Assurance program and the excellent peer review process that is performed.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the Hospital Administrator, Chief of Medical Staff, entire Medical Staff, Medical Director of Quality Assurance, Director of Utilization Review, and the Director of Medical Records. Our overall percentage of deaths is well within the predicted range of mortality rates presented by HCFA with no outliers of any diagnostic category.

As previously stated, review by this facility is always by individual case, and is conducted in an on-going fashion, not just when statistics such as the mortality data are released.

Thank you for the opportunity to present this response.

Sincerely,

Michael E. Cooper R.D., N.H.A.
Administrator

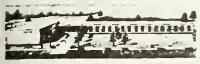
Robert W. Taylor Jr. M.D.
Chief of Staff

Mike Weaver MD

Mike Weaver M.D.
Medical Director of Quality Assurance

HOSPITAL = 190151 RICHLAND PARISH HOSP RAYVILLE RAYVILLE LA

	DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
	ALL CAUSES	835	14 %	9 TO 17 %
5	CA - CANCER	55	27 %	20 TO 47 %
6	CE - CEREBROVASCULAR ACCIDENTS	26	20 %	15 TO 49 %
0	EY - OPHTHALMOLOGIC DISEASE	3	0 %	0 TO 100 %
4	GC - GASTROINTESTINAL CATASTROPHES	18	33 %	8 TO 48 %
13	GI - GASTROINTESTINAL DISEASE	99	8 %	2 TO 12 %
9	GU - UROLOGIC DISEASE	37	19 %	1 TO 21 %
0	GY - GYNECOLOGIC DISEASE	7	0 %	0 TO 86 %
5	HL - LOW-RISK HEART DISEASE	66	5 %	1 TO 13 %
6	HM - SEVERE CHRONIC HEART DISEASE	41	17 %	11 TO 37 %
2	HS - SEVERE ACUTE HEART DISEASE	20	40 %	21 TO 62 %
11	ME - METABOLIC/ELECTROLYTE DISTURBANCES	15	7 %	4 TO 45 %
0	OP - ORTHOPEDIC DISORDERS	33	0 %	0 TO 22 %
20	PN - PULMONARY DISEASE	115	20 %	14 TO 31 %
1	RN - RENAL DISEASE	9	44 %	7 TO 64 %
3	SE - SEPSIS	13	30 %	17 TO 67 %
10	TR - SEVERE TRAUMA	16	13 %	1 TO 35 %



Richland Parish Hospitals

P. O. Box 388
Rayville, Louisiana 71269

507 Cincinnati
Delhi, Louisiana 71232

Provider Number - 190149

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

October 23, 1987

Dear Sirs,

Richland Parish Hospital at Delhi, is a 43 bed acute care facility who treats many patients with major medical and surgical illnesses. We are a full service medical center offering specialty areas in pulmonary medicine, general surgery, urology, internal and general medicine.

It should be kept in mind that, according to the Northeast Louisiana University Center for Gerontology, that the national average population for elderly is 12%. The average for elderly in Richland Parish and surrounding parishes that we serve is 20%. It should be further noted that of this number, nearly half live at or near the poverty level. Further, Richland Parish has recently been shown to have a higher incidence of cancer, according to the latest North Louisiana Tumor Registry Report, than any other parish in Northeast Louisiana.

Because of the age, income levels, and general acuity of our average patient, the hospital is extremely pleased to have death levels below those which might be expected.

The medical staff at the hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. The Joint Commission on Accreditation of Health Care Organizations bestowed on this facility its approval of the hospital Quality Assurance program and the excellent peer review process that is performed.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the Hospital Administrator, Chief of Medical Staff, entire Medical Staff, Medical Director of Quality Assurance, Director of Utilization Review, and the Director of Medical Records. Our overall percentage of deaths is well within the predicted range of mortality rates presented by HCFA with no outliers of any diagnostic category.

As previously stated, review by this facility is always by individual case, and is conducted in an on-going fashion, not just when statistics such as the mortality data are released.

Thank you for the opportunity to present this response.

Sincerely,

Michael E. Cooper P.D., N.H.A.
Administrator

Dr. Hugh C. Watson M.D.
Chief of Staff

Dr. Samuel P. Scurria M.D.
Medical Director of Quality Assurance

500 Rue de Santé • LaPlace, Louisiana 70068

October 6, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

River Parishes Hospital in LaPlace, Louisiana, Provider Number 190193, is in receipt of the hospital mortality information provided by your agency.

Upon further analysis of the hospital's internal data, the mortality information appears accurate and indicates that this facility's performance falls within predicted ranges in each diagnostic category.

Given this result, therefore, this hospital does not contest your agency's methodology at this time. Upon more detailed analysis, however, the hospital reserves the right to seek clarification of the results as appropriate.

Sincerely,

Michael D. Snow
Managing Director

MDS/bl

Riverland
MEDICAL CENTER
P.O. Box 111 • Ferriday, Louisiana 71334

FERRIDAY (318) 757-6551
VIDALIA (318) 336-7148

JONESVILLE (318) 339-66?c
MONTEREY (318) 386-736c

October 23, 1987

William L. Roper, M.D.
Administrator
HCFA Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

SUBJECT: Mortality Information
Riverland Medical Center, Hospital Code #190089

Dear Dr. Roper:

The following information and reply are forwarded to you for inclusion with the release of hospital specific mortality data for Riverland Medical Center, Ferriday, Louisiana.

Riverland Medical Center is a forty-nine bed Medical/Surgical Acute Care facility with three beds dedicated to ICU/CCU patients. During the year of 1986, Riverland Medical Center provided a seven bed Skilled Nursing Facility within the hospital. The Skilled Nursing Facility was terminated in December, 1986.

The average census of Riverland Medical Center is comprised of thirty-eight percent (38%) Medicare patients.

The Medical Staff, Administration, Medical Records Department, and Director of Nursing Service conduct a review of all patients who expire at this facility regarding medical management and overall care. Mortality reviews are completed by the Utilization Review Committee of the Medical Staff and are an ongoing part of the Quality Assurance program at Riverland Medical Center.

The hospital specific mortality data provided by HCFA has been reviewed by the Administrator, Physician Chairman of the Utilization Review Committee, the Chief of the Medical Staff, the Director of Medical Records, and the Director of Nurses. This review has confirmed that the statistics are correct with only minor exceptions and that the hospital mortality rates are within the predicted mortality range for overall deaths from all causes and for fifteen of the sixteen specific diagnostic categories.

The following summarizes our findings in the one diagnostic category in which the actual mortality exceeded the predicted range:

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

October 23, 1987
Mortality Information

Diagnostic Category: Cancer

The predicted percentage of deaths in this category was reported to be seventeen to sixty-eight percent (17%-68%). The actual mortality rate was computed to be seventy-five percent (75%).

It should be noted that:

1. Only nine deaths were noted in this category.

2. Two of these deaths were patients who had been diagnosed several years earlier and had received unsuccessful radiation therapy at other medical facilities specializing in cancer treatment.

3. One patient was transferred at the patient's request to a Veteran's Administration Hospital for therapy; the patient expired at the V.A. Hospital.

The Medical Staff of Riverland Medical Center, the Administration and patient care departments will continue to monitor and review all mortality cases to insure that quality care is rendered to every patient. Our Quality Assurance Program provides a constant effort to monitor the quality of patient care and identify every opportunity to improve patient care.

Sincerely,

Vernon R. Stevens, Jr.
Administrator

Dennis LaRavia, M.D.
Chief of Staff

Gary Smith, M.D.
Utilization Review Chairman

RIVERSIDE
COMMUNITY HOSPITAL
4900 Medical Drive
Bossier City, LA 71112
318 747-9500

COMMENTS ON THE HCFA MORTALITY DATA

RIVERSIDE COMMUNITY HOSPITAL
BOSSIER CITY, LOUISIANA

The data used by HCFA indicates that a total of 46 Medicare patients admitted to Riverside Community Hospital died within 30 days of admission. Our own records indicate that 584 Medicare admissions occurred in 1986 and HCFA's records indicate 343 beneficiaries were treated in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals.

Based on Riverside Community Hospital's review of HCFA Mortality Data, we have discovered that five of the alleged mortalities were actually alive upon discharge from this facility. Of the remainder 41 mortality cases, 26 or 63% were designated DNR's (Do Not Resuscitate) either upon admission or shortly thereafter.

It was also noted that three dates of death were found to be incorrect. The correct data is attached for your reference.

An indepth breakdown according to High Risk Diagnosis follows:

CA - Cancer: Of the eight patients whom are listed, one did not expire in this facility. The other seven were all listed as DNR's upon admission or shortly thereafter. All of these patient had metastasis and were longterm cancer patients. With the patients being classified as DNR's, death was eminent according to the physicians findings and the inevitable course of metastatic carcinoma.

CE - Stroke: Of the five patients whom are listed, one did not expire in this facility. Three of the remaining four were listed as DNR's upon admission or shortly thereafter. The remaining patient suffered a massive inoperable bleed into his dominant sphere.

HS - Severe Acute Heart Failure: Fifty per cent of patients in this category were admitted with CPR in progress. The remaining fifty per cent had long-standing history of cardiac disease.

HM - Severe Chronic Heart Disease: Of the five patients listed in this category, two patients did not expire in this facility. Remaining three patients were categorized as DNR either upon admission or shortly thereafter.

GC - Gastrointestinal Catastrophes: The one patient listed in this category, suffered multiple post-operative complications.

PN - Pulmonary Disease: Fifty per cent of patients listed were admitted with or shortly thereafter put on DNR status.

SE - Sepsis: Six out seven patients listed in this category were DNR's.

An indepth breakdown according to Low Risk Diagnosis follows:

HL - Low Risk Heart Disease: The one patient listed in the category following multiple post-operative complications was designated as DNR.

GI - Gastrointestinal Disease: Two of three patients listed were designated as DNR's. The remaining patient's family requested life support systems be discontinued.

OP - Orthopedic Condition: The one patient listed in this category suffered a massive pulmonary emboli secondary to the operative procedure.

UN - Other Conditions: One of the five patients did not die in this facility. Three of the remaining four patients had multiple severe complications making death inevitable.

LA 122.2

HOSPITAL ID NUMBER ELSEWHERE

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LTRS)	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINCIPAL DIAGNOSIS	PRINCIPAL PROCEDURE
[redacted]		CA	073	F	09/22/86	09/23/86	09/23/86	1579	
		CA	061	F	03/11/86	03/16/86	03/16/86	2330	
		CA	073	M	02/17/86	03/11/86	03/17/86	1572	4131
		CA	067	M	03/07/86	03/09/86	03/09/86	1623	
		CA	070	M	01/03/86	01/09/86	01/09/86	1570	
		CA	060	F	03/03/86	03/10/86	03/10/86	2030	
		CA	068	F	06/25/86	06/26/86	06/26/86	1579	
		CA	079	F	04/08/86	04/17/86	04/17/86	1990	3322
		CE	069	M	02/05/86	02/10/86	02/10/86	431	
		CL	069	F	12/15/85	12/26/85	01/01/87	436	
		CE	083	F	03/03/86	03/04/86	03/04/86	4349	
		CL	069	M	07/10/86	07/13/86	07/13/86	431	
		CL	094	M	11/07/86	11/12/86	11/12/86	436	
		GC	063	F	01/14/86	02/12/86	02/12/86	5609	4573
		CI	062	F	09/12/86	10/03/86	10/03/86	5F200	4562
		GI	069	F	01/24/86	02/01/86	02/01/86	5E210	4576
		GI	049	M	09/12/86	09/30/86	09/30/86	57411	5122
		HL	067	F	01/23/86	02/01/86	02/01/86	40290	5551
		HM	070	F	03/26/86	04/01/86	04/13/86	4280	
		HM	062	M	11/14/86	11/22/86	11/29/86	4254	
		HM	067	F	01/01/86	01/06/86	01/06/86	4280	
		HM	079	M	03/06/86	03/16/86	03/16/86	4280	
		HM	084	F	03/27/86	04/09/86	04/09/86	4280	5491
		HS	068	M	11/12/86	11/15/86	11/15/86	4102	3772
		HS	065	F	12/26/86	12/27/85	12/27/86	4275	4513
		HS	061	M	09/25/86	09/25/86	09/25/86	4101	
		HS	072	M	02/02/86	02/03/86	02/03/86	4275	
		OF	A 071	M	12/25/85	01/04/86	01/04/86	71595	8159
		PV	091	F	12/20/85	01/06/86	01/06/86	5070	
		PN	098	M	06/20/86	07/07/86	07/07/86	486	4513
		PN	072	M	06/30/86	07/01/86	~~07/02/86~~ 07/01/86	481	
		PN	076	M	02/07/86	~~02/28/86~~ 03/1/86	~~02/28/86~~ 03/1/86	496	3323
		PN	074	F	06/10/86	06/26/86	06/26/86	486	
		PN	087	M	08/15/86	08/29/86	08/29/86	496	
		SL	072	F	06/03/86	06/04/86	06/04/86	0389	
		SE	076	M	05/11/86	05/21/86	05/21/86	0389	9635
		SL	067	F	06/14/86	06/27/86	06/27/86	0389	
		SL	077	F	07/20/86	07/27/86	07/27/86	0389	
		SL	090	M	04/18/86	04/24/86	04/24/86	0389	
		SL	065	F	10/07/86	10/14/86	10/14/86	0389	
		SE	082	F	07/08/86	07/16/86	07/16/86	0389	
		UN	060	M	04/12/86	04/20/86	~~04/21/86~~ 04/20/86	3481	0331
		UN	063	M	01/27/86	01/30/86	01/30/86	2859	
		UN	076	F	12/28/85	01/11/86	01/11/86	0389	8417
		UN	067	F	02/25/86	03/01/86	03/01/86	44422	3608
		UN	094	F	09/29/86	10/15/86	10/16/86	7854	8417

* corrected dates of discharge & death.

riverside
medical center

October 14, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to your agency's selected mortality information regarding Riverside Medical Center's 1986 Medicare patients prior to publication.

As you know, Riverside Medical Center is an acute care hospital with a licensed capacity of seventy-six beds. Located in the southeastern area of Louisiana, our hospital case mix includes many patients with major medical and surgical illnesses.

At Riverside Medical Center, mortality review is an important part of our quality assurance program and mortality review activities are conducted monthly in medical and surgical staff meetings. Intensive reviews of all deaths at our hospital are conducted by members of our medical staff, administration and appropriate nursing personnel.

During mortality reviews, the overall plan of care for any patient who has died is scrutinized by our staff physicians and any questions regarding the medical management of a case are directed to the attending physician. Using this process, Riverside Medical Center addresses any mortality problems that may arise on an immediate basis.

Although our internal review of 1986 mortality data was complete in January of this year, the selected information you intend to publish has again been reviewed by the hospital administrator, the hospital board, the chief of staff, the medical staff and the quality assurance department. After our second review of this information, we again determine that there are no adverse trends or patterns that can be identified as a threat to the high quality health care provided at Riverside Medical Center.

South Main Street
P.O. Box 528
Franklinton, LA 70438
(504) 839-4431

Our quality assurance program and its continuous monitoring systems constantly provide quality indicators at levels that are in excess of standards to ensure quality care. Although we believe that our system is more than adequate and well above standard, we plan to continue to refine our methods to provide the best possible care to the citizens of our service area.

Once again, let me thank you for the opportunity to respond to your agency's selected mortality information regarding Riverside Medical Center's 1986 Medicare patients.

Sincerely,

James Branon

James Branon
Administrator

Gerald L. Foret, MD
Chief of Staff

Sabine Medical Center
A National Healthcare, Inc. Facility

240 Highland Drive
Many, Louisiana 71449-3718
318/256-5691

ID Number-190047

October 14, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

We are pleased to submit our comments on the mortality data to be released in December. These comments represent our perspective on what the HCFA numbers mean to us at Sabine Medical Center. We understand that this data is not a measure of hospital performance. The outcome data that we have been presented with will assist us in refining our quality review activities.

Sincerely,

Tom Rozewicz
Administrator

Sabine Medical Center
Many, LA 71449

Reviewing the Numbers

The number of cases included in the HCFA analysis was 370. The actual number of Medicare admissions for 1986 was 652. The reason for the variance is that the HCFA analysis includes only the last admission for patients admitted to hospitals more than once during the year. The data used by HCFA indicate that a total of 55 Medicare patients admitted to Sabine Medical Center died within 30 days of admission. Of these, 37 died while still a patient of the hospital, 18 were alive at discharge but subsequently died.

There was only one diagnostic category in which the actual mortality rate is lower than the lower end of the predicted mortality range or higher than the upper end. This category is the pulmonary disease category. Of the 9 patients who died with pulmonary disease, 5 of them died after discharge from the hospital. Since Sabine Medical Center is a rural acute care facility, patients who present to the facility in acute respiratory failure and/or who require long-term ventilatory care are usually transferred to a tertiary care facility in Shreveport. The other reason that this rate is lower than the low end of the predicted rate is that some patients will die of complications of pulmonary disease such as congestive heart failure.

The deaths in the diagnostic category of pulmonary disease reveals that greater than 50% of these deaths occurred after discharge. All of these deaths were anticipated and planning was done for alternative care or referral to a tertiary care facility. The other diagnostic category in which greater than 50% of the deaths occurred after discharge was cerebrovascular accident. All of these deaths were anticipated and planning was done prior to discharge.

Verification of the Data

A thorough review of the case listing has shown that all patients were acutally hospitalized at Sabine Medical Center and their date of death, if before discharge, was verified. Physician offices were contacted to verify that the patient did die after being discharged from the hospital. A review of all 55 case listings shows no errors in coding.

There was one error in the case listing. The date of death on the patient with the [redacted] was listed as March 22, 1986. It should have been March 21, 1986.

Interpretive Comments

Sabine Medical Center is located in Many, La., a rural community of 4,200 residents in northwest Louisiana. There is one hospital with 68 beds and two nursing homes with 188 beds. 15% of the population is over 65 years old with the median age being 32 years. In addition, we are in close, proximity to Toledo Bend Lake, a vast recreational area which is actively marketed to retirees.

As evidenced by our 49.6% Medicare utilization rate for 1986, the type of patients treated at Sabine Medical Center are for the large part geriatric. There were 652 Medicare admissions for 1986 but the HCFA data used only 370 cases. The significance of this is that there were several patients requiring multiple admissions during the year. The multiple admissions could be affected by the fact that many of these patients present with multiple medical problems which may be due to their age and the economic environment.

Review of the medical records of patients who died at Sabine Medical Center within 30 days of admission reveals the following:

1) the death was the expected outcome at the time the patient was admitted or discharged;
2) the death was not expected at the time of admission or discharge but it was a significant possibility (e.g. the patient was under treatment for a chronic condition); or

3) the deaths can be plausibly attributed to an unusually large number of complicating conditions.

Our mortality rate is not above the predicted rate but the review of the medical records of all those who died indicates a shortage of nursing home beds in the area. In addition, our review proved that the majority of the patients we treat have extremely acute or chronic degenerative conditions. Much of this can probably be attributed to the fact that the mean age of these 55 patients was 78.6 years at the time of death.

Savoy Medical Center, Inc.
801 Poinciana Avenue
Mamou, Louisiana 70554
Telephone (318) 468-5261

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

We understand and share in your strict caution to all hospitals, our communities and the media regarding the misuse of this statistical Medicare information, the Health Care Financing Administrations' (HCFA) Medicare Predicted Mortality (Death) Rates. In other words, taking these numbers and trying to make them represent something else entirely. We are also aware, as you are, that this data alone is not a final measure of the quality of care at any individual hospital and should not be used to make judgement and/or quality of care comparisons among hospitals!

Although, by your own admission, the methodology used this year to calculate these Predicted Mortality Rates is self-limiting, we will thus accept them in the spirit in which they were presented, noting that the ability of this HCFA process to detect differences in quality has never been evaluated! We also make note of the fact that the Predicted rates wrongly assume that each hospitals' patients are "average". Measures of the severity of illness, in other words, how sick the patients were at the time of admission, are not accounted for in this years process as well. We feel its additionally important to mention that not all the deaths that were credited to our hospital were actual deaths that occurred within the hospital itself. Rather these were deaths that occurred within 30 days of the last admission to the hospital in 1986.

Nevertheless, despite the obvious limitations of this data, we feel we can merge this data into our already on-going Quality Assurance and Utilization Review information and activities to be used as an additional aid in helping us maintain and ensure our overall Quality of Care. We feel the best utilization of these Predicted Mortality Rates is just as we would use other data we would normally generate in-hospital. By simply using this information as another screening mechanism, it can help us identify or suggest areas for more focused internal review, just as our other data now does. In this way, using members of our hospital-wide Quality Assurance and Utilization Review staff, we can determine if an actual quality problem does exist or if unusual circumstances were involved. We can then implement timely corrective action if needed, as is our normal process. Our Quality Assurance and Utilization Review staff is a multi-disciplinary one consisting of Medical Staff Physicians, Director of Nursing, Director of Associated Services, Director of Medical

Records, DRG Coordinator, Quality Assurance Coordinator, Utilization Review Coordinator, Representatives of Discharge Planning, Social Services, Home Health, Hospital Administration, and the Director of Skilled Nursing Facility. Our normal Quality Assurance procedures involve using this group of individuals anytime we have information we feel has any bearing on our evaulation of our Quality of Care in any area of the hospital.

Although our Predicted Mortality Rates did not give us cause for significant concern for focused review in any one particular area, we did feel it necessary to review all of the cases that went into arriving at these mortality rates, as part of our own Quality Assurance Program. Our review re-established the importance of the absence of the severity of illness factors and indicated other factors and trends specific to our hospital not included in HCFA's process.

Our research showed a significant number of our Medicare patients, especially in our high risk categories were transfers and referrals from Nursing Homes, Skilled Nursing Facilities and other hospitals, admitted through our Emergency Room. These types of patients are sicker upon admission and present a higher risk for surgery and treatment than the "average" patients that HCFA uses as a basis for their data. These patients, some in their 80's and 90's usually have multiple medical and surgical complications which have a direct effect upon the treatment received and the overall outcome of the admission. We find this fact to be especially true in two of our high risk categories, cancer and cerebrovascular accidents (CVA-brain stroke). In our area, we see a significant number of cancer patients and mortality is often times not from the cancer or the CVA itself, but from the critical complications of these two diseases.

Our particular community also does not have a hospice (facility for the terminally ill) and at the same time suffers from a shortage of nursing home beds. Because of this, our chronic or terminally ill patients receive home care as well as nursing home care when appropriate and available, and are transferred and treated in the hospital even when death is the expected outcome at the time of admission and/or discharge. In a number of these situations, the family and the patient has requested that no heroic measures be undertaken to prolong their suffering, and we have abided by their wishes!

Further study revealed a direct correlation between our higher risk admissions (cancer, CVA, heart disease), mortality (death), and the lifestyle unique to our part of the state. As a provider, we have continued to try to alert our community, through our Physicians, about the long term effects of certain aspects of our unique lifestyle, here in Acadiana, when not combined with proper diet and exercise. Along this same line, our hospital, in 1986, opened a new two floor addition to our facility. During this same year, we added several new services to include Skilled Nursing Care, Short Stay, and OUtpatient Surgery. The addition of these services, along with the new wing, has resulted in an increase in the number of the more seriously ill patients we can treat. It also brings with it, however, a corresponding and expected increase in the mortality rate of our high risk admissions because we are seeing more of the very sick.

The provision of the highest Quality of Care level that we can attain is of paramount concern to the Governing Board, Hospital Administration, the Medical Staff as well as to the employees of Savoy Medical Center. Our on-going Quality Assurance and Utilization Review activities, through administrative orders, help to ensure this hospital-wide commitment. Hospital Mortality data is only one aspect of a total Quality Assurance Program. The American Hospital Association along with other organizations including the Joint Commission on Accreditation of Health Care Organization (JACH) are developing methods of evaluating hospital quality that incorporate factors other than simply mortality rates. When these tasks are completed, we feel the public will then have been given a workable and useful tool in order to fulfill their individual needs. We look forward to these days!

Sincerely,

J. E. Richardson
Executive Director

JER/cs

SCHUMPERT MEDICAL CENTER
915 Margaret Place
P. O. Box 21976
Shreveport, LA 71120-1976

19 October 1987

William L. Roper, M.D.
Health Care Financing Administrator
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics for calendar year 1986 prior to public disclosure. Administration, UR Coordinator, Medical Staff, and O.A. Director have reviewed the report and find that the majority of the data is accurate. However, this study is based on 4544 Medicare patients, as opposed to the 7655 actual Medicare patients treated at Schumpert Medical Center in 1986. Therefore, the data presented in this study does not give a complete picture of the patient population treated at Schumpert Medical Center.

Schumpert Medical Center is a 635-bed nonprofit acute care facility that is part of the Sisters of Charity of the Incarnate Word Health Care System. Our patient population includes many people with serious medical and surgical illnesses. We are a full-service medical center whose mission is to offer care to all people in need, with an emphasis on the indigent and elderly. A large number of seriously ill patients and people whose conditions require continuous care, both inpatient and out, are attracted to our facility by the specialty care offered in the following areas:

> i.e., cancer; major orthopedic; heart and lung rehabilitation programs; chronic kidney, heart, and lung disease; open heart surgery; diabetes programs; maternity; major stomach and intestinal disease; brain disorders; trauma; and adult and pediatric critical care.

In addition, the expertise found in our medical staff and the advanced technologies available in our hospital combine to make us a major referral center for this region. Examples of the technology available include: magnetic resonance imaging, lithotripsy (crushes kidney stones), cancer treating technologies, helicopter transport, kidney dialysis and transplant, heart center, lung treatment and rehabilitation, direct computer link between a physician office and the hospital.

As a nonprofit health care provider, our mission is to offer an environment of hope, healing and peace to all who seek relief in times of birth, sickness, and death.

A part of this caring is to offer public education programs promoting health care and wellness, such as family life seminars; nutritional education; hypertension and glaucoma screenings with at least monthly cholesterol free sight and hearing screening; outreach and exercise programs; hospice and home health; telephone links between the hospital and the home bound; and health awareness fairs.

Since heart disease is the number two (2) cause of death in the nation, the classification "Low Risk" is extremely misleading. Many of the patients in this category experienced high risk procedures such as open heart surgeries and heart catheterization, which must be taken into account in the formation of a category such as "low risk" heart disease. One third of the mortality statistic reported in this category were transferred to Schumpert Medical Center from other hospitals as the recognized facility which could best meet the patient's needs.

In order for the release to be effectively utilized by both Schumpert Medical Center and the public, the model must take into account such factors as severity of illness, cause of death, genetic make-up, socio-economic status, and surgical procedures.

Without these changes to the model, the differences in mortality rates between hospitals should not be interpreted as differences in the quality of care provided by those hospitals. However, some data from this release can be used by the Medical Staff of Schumpert Medical Center, who will continue to monitor all mortality cases for quality and appropriateness of care rendered to the individual patient, as has been their practice. Trending analysis from this constant monitoring is a continuing endeavor to assist Schumpert Medical Center in identifying opportunities to provide the highest possible, quality, patient care available.

Sincerely,

Sister M Agnesita

Sister M. Agnesita
Administrator
SCHUMPERT MEDICAL CENTER

SMA/hm

CONFIDENTIAL--PATIENT INFORMATION

LIST OF DISCREPANCIES IN 1986 MORTALITY DATA

The following discrepancies in the date of death were noted in the mortality data supplied to Schumpert Medical Center. Nine (9) patients expired after discharge from Schumpert Medical Center according to HCFA data. However, chart review verified that these nine (9) patients actually died while in the hospital:

CATEGORY	PATIENT ID NUMBER (HIC)	NAME	AGE/SEX	ADMIT DATE	HCFA DATE OF DEATH	SCHUMPERT DATE OF DEATH
CA	[redacted]		66/F	11-22-86	12-12-86	12-08-86
GC			93/M	08-19-86	08-31-86	08-19-86
GI			70/M	05-15-86	05-31-86	05-16-86
HL			78/F	10-09-86	10-16-86	10-15-86
HL			96/F	07-06-86	07-16-86	07-13-86
HM			68/F	01-30-86	02-28-86	02-02-86
HS			62/M	02-01-86	02-06-86	02-04-86
PN			92/F	11-02-86	11-07-86	11-06-86
TR			97/F	11-07-86	11-24-86	11-17-86

In addition to the above discrepancies, the below listed patient was identified whose last hospital admission before death was in 1987 rather than in 1986. Therefore, this patient should be excluded completely from the 1986 mortality statistics.

CATEGORY	PATIENT ID NUMBER (HIC)	NAME	AGE/SEX	ADMIT DATE	DISCHARGE DATE	HCFA DATE OF DEATH
ME	[redacted]		78/M	12-18-86	12-23-86	01-11-87

This patient was admitted to Schumpert Medical Center again on January 5, 1987, and discharged January 8, 1987. The claim for this hospital admission was filed January 18, 1987.

SLIDELL MEMORIAL HOSPITAL
AND MEDICAL CENTER
ST. TAMMANY PARISH HOSPITAL
SERVICE DISTRICT NO. 2
BOARD OF COMMISSIONERS
GUS A. FRITCHIE, JR.
Chairman
EDWIN POLK
Vice-Chairman
ORA H. CRAWFORD
MARY LEE DANIEL
MARVIN E. KENDRICK, M.D.
JOHN P. PASQUA
JANIE W. McKENZIE

Dedicated to our founders, benefactors, and those who served us in the armed forces.
A Voluntary, Not-For-Profit Hospital

ROBERT P. ATKINSON
District Secretary - Treasurer
Chief Executive Officer

October 20, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper:

Thank you for allowing us the opportunity to respond to the release of data on hospital mortality rates for Medicare patients in 1986. These data have been reviewed by Administration, Quality Assurance Committee and the Medical Records Department. Our overall percentage is in the low to mid range of the predicted rates.

Slidell Memorial Hospital and Medical Center is a 182 bed acute care facility. We are a full service medical center offering care in specialty areas of open-heart surgery, oncology as well as general medicine and surgery. Slidell Memorial is accredited by the Joint Commission for Accreditation of Healthcare Organizations.

Mortality review is performed by the Medical Staff on the chart of every patient who expires at this facility regarding medical management and overall care.

Thank you again for the oportunity to present this response.

Sincerely,

Robert P. Atkinson
Chief Executive Officer

Esteban Romano, MD
Chief of Staff

William Buffat, MD
Medical Director

William Williams, MD
Quality Assurance

Gus A. Fritchie, Jr., Chairman
St. Tammany Parish Hospital
Service District #2

Southern Baptist Hospital

2700 Napoleon Avenue
New Orleans, Louisiana 70115

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to comment on the release of hospital mortality rates. The Hospital Administration and Medical Staff has carefully reviewed the data and has noted that our Hospital's actual rate fell either below or within the predicted mortality rates for each category.

Southern Baptist Hospital serves as a 533 bed acute care referral center for the most intensive and sophisticated types of medical and surgical care. The Hospital is noted for excellence in cardiac surgery, microsurgery, neurosurgery, orthopedic surgery, plastic and reconstructive surgery and organ transplantation. The Hospital was the first private hospital in Louisiana to operate a neonatal-pediatric intensive care unit to care for the most critically ill newborns and children.

The Medical Staff at Southern Baptist Hospital conducts an on-going process of Quality Assurance and Peer Review. The Medical Staff conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care in order to ensure that we continue to meet and exceed quality care standards. The Joint Commission on Accreditation of Hospitals awarded the Hospital its highest commendations for both Quality Assurance and Peer Review as well as the maximum level of accreditation it bestows.

Again, thank you for the opportunity to present this response. We support any efforts to produce and publish meaningful accurate information which will assist the public in choosing the finest quality health care services.

If you or anyone receiving this information has any questions, please do not hesitate to call.

Sincerely,

Nelson E. Toebbe
President
Southern Baptist Hospitals, Inc.

Robert Royce Sistrunk, M.D.
Chairman, Board of Directors

Anthony G. Poche', M.D.
President, Medical Staff

/lgs

WILLIS-KNIGHTON MEDICAL CENTER
WK SOUTH
2510 Bert Kouns Industrial Loop
Shreveport, Louisiana 71118

James K. Elrod
President

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The following information for Willis Knighton South (provider number 190194) is to be attached to the Hospital Specific Report for the period of January 1, 1986 to December 31, 1986, prior to public disclosure.

Willis Knighton South, which is a 72 bed acute care facility, has a case mix of many patients with major and minor medical and surgical illnesses. This medical facility offers specialty fields of which include medicine, surgery, oncology, major and minor orthopedic and cosmetic surgery services as well as a Chemical Dependency Unit for our community.

For Quality Assurance, 100% of all deaths at Willis Knighton South are reviewed for pertinence and overall care of each patient. Mortality Review is an on-going process by our Medical Staff, at Willis Knighton South, along with many additional monitors to assure our patients the best quality of care. This facility has met all accreditation standards set by the Joint Commission on Accreditation of Healthcare Organizations for our Quality Assurance program and our efficient Medical Staff Peer Review process. In achieving those optimal standards, Willis Knighton South has been accreditated for the full three year period.

This hospital specific Mortality Data reported by the Health Care Financing Administration (HCFA) is not but one of the many indicators of the quality of care rendered by Willis Knighton South. This Mortality Data, alone, is by no means a report card that reflects the total quality of care administered at our institution.

Willis Knighton South's Mortality Data has been reviewed by hospital personnel as well as medical staff representatives for accuracy. Our data falls within the study's acceptable ranges set specifically for Willis Knighton South.

Willis Knighton South's Quality Assurance and Peer Review Program which, again, reviews 100% of all mortality cases meets the standards set by the Joint Commission. These procedures will not only remain on-going due to a requirement, but more so to promote optimal quality of care for patients treated at Willis Knighton South in the future.

Thank you for allowing this response.

Sincerely,

James H. Elrod, President
Willis Knighton Health Systems

Hoyet Chance M.D.

Hoyet Chance, M.D.
Cheif of Staff
Willis Knighton Health Systems

Saint Anne General Hospital
Lafourche Parish Hospital Service District No. 2
P. O. Box 440
Raceland, Louisiana 70394

W. LUCIEN SIMPSON, M.D., CHAIRMAN
MILTON D. BOURGEOIS, JR., VICE-CHAIRMAN
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LEONARD J. ST. PIERRE, COMMISSIONER
MICHAEL R. ROBICHAUX, M.D., COMMISSIONER
BERNARD J. BOYNE, ADMINISTRATOR

COMMENTS ON THE HCFA MORTALITY DATA

PROVIDER: 190109

DATA VERIFICATION

The data used by HCFA indicate that St. Anne General Hospital admitted a total of 499 Medicare patients in 1986 and that of these patients, 54 expired within 30 days of admission. Of these, our records indicate that 33 expired while still a patient in the hospital. The remaining 21 patients which HCFA has indicated as having expired within 30 days of admission died after discharge.

Our own records indicate that 872 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to other facilities. Based on the data provided by HCFA, we have no way of verifying this.

Any statistical information regarding patients dying after discharge is impossible to retrieve as information concerning death after discharge is not included in the patient's hospital medical record.

INTERPRETIVE REMARKS

With one exception, St. Anne General Hospital's actual mortality rate fell well with in the range of the predicted mortality rates in all diagnostic categories. In the one category which fell outside the predicted range (Renal Disease), there was a total of three cases. The HCFA data indicates that all three patients expired. Two of them expired while still patients in the hospital. Upon review of the medical records of each of these three patients by Medical Staff Quality Assurance, it was determined that the two patients who expired in the hospital died with a proximal cause and principal diagnosis of renal failure. Their deaths occurred in association with other severe and possibly terminal illnesses.

Quality of patient care is of the utmost concern to St. Anne General Hospital's Board of Commissioners, Administration, and Medical Staff. It is important to note however, that a mere listing of statistics is not an indicator of the quality of patient care rendered at any facility. Quality of care can be evaluated and measured only through peer review processes.

It should be noted, as well, that the data presented by HCFA is not representative of overall mortality rates in that only Medicare deaths are considered. Also, the methodology utilized for determining inpatient mortality differs significantly from the traditional, and more accurate methods used by hospitals nationwide in that HCFA has included deaths occurring after discharge.

In summary, although interesting to know, mortality rates in and of themselves are not indicators of the quality of care provided by this or any other facility. Specific methods of evaluating the quality of hospitals are being pursued by the Joint Commission and the American Hospital Association. Our hospital looks forward

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

with anticipation to learning the results of the efforts of these organizations.

Tania L. Cody, RRA
Director, Medical Records
PRO Contact Person

Bernard J. Boyne
Chief Executive Officer

ANALYSIS OF REPORTING ERRORS--ST. ANNE GENERAL HOSPITAL (PROVIDER 190109)

DIAGNOSTIC CATEGORY	DEATHS REPORTED BY HCFA		DEATHS VERIFIED BY ST. ANNE	
	IN-HOSPITAL	POST-HOSPITAL	IN-HOSPITAL	POST HOSPITAL*
CA--CANCER	5	6	6	
CE--CEREBROVASCULAR ACCIDENTS	2	3	2	
EY--OPHTHALMOLOGIC DISEASE	0	0	0	
GC--GASTROINTESTINAL CASTASTROPHES	0	0	0	
GI--GASTROINTESTINAL DISEASE	2	0	2	
GU--UROLOGIC DISEASE	0	0	0	
GY--GYNECOLOGIC DISEASE	0	0	0	
HL--LOW RISK HEART DISEASE	0	0	0	
HM--SEVERE CHRONIC HEART DISEASE	5	1	5	
HS--SEVERE ACUTE HEART DISEASE	8	2	8	
ME--METABOLIC/ELECTROLYTE DISTURBANCES	1	2	1	
OP--ORHOPEDIC DISORDERS	0	1	0	
PN--PULMONARY DISEASE	4	2	4	
RN--RENAL DISEASE	2	1	2	
SE--SEPSIS	0	0	0	
TR--SEVERE TRAUMA	0	0	0	
UN--OTHER DIAGNOSES	3	4	3	
TOTAL ALL CATEGORIES	32	22	33	

*POST-HOSPITAL DEATHS WERE NOT VERIFIED.

Saint Charles
GENERAL HOSPITAL

COMMENTS ON THE HCFA MORTALITY DATA

ST. CHARLES GENERAL HOSPITAL
New Orleans, Louisiana

The data used by HCFA and verified by St. Charles General Hospital, indicate that a total of 97 Medicare patients died within 30 days of admission. Of these, 81 died while still a patient of the hospital, while 16 died after discharge. (One death was noted to be reported one day after discharge, when the patient expired in the hospital and this was the reason for discharge. See corrected data.) Our records indicate that 1,981 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries.

Our small facility has a large patient population in Cardiac, Gastrointestinal, Orthopedic and Pulmonary Disease categories, and we have a hospital-sponsored Dialysis Unit.

We have no deaths attributed to Orthopedic Disorders, Renal Disease, Gynecological Disease, or Ophthalmologic Disease, and are below the expected range for mortality in Severe Acute Heart Disease, and Sepsis, for which we are well pleased. We feel that this data reflects the exceptional and dedicated care of our Medical Staff and Intensive Care Unit Staff in conjunction with all other hospital departments. All other categories are in the low to mid range of their predicted values.

Of those patients (16) who expired after discharge, 5 were under hospice services for terminal care, one case was removed by family members against medical advice (in extremely guarded condition), and 8 were discharged in poor or guarded condition to other nonacute facilities.

These statistics and our preliminary review of the medical records have given the Quality Assurance Program some basis for investigation into ways to further improve our quality of patient care.

Louis Levy, M.D.
Medical Director

Richard Freeman
Chief Executive Officer

3700 SAINT CHARLES AVENUE, NEW ORLEANS, LOUISIANA 70115 • (504) 899-7441
A National Medical Enterprises Health Care Center

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

St. Frances Cabrini
HOSPITAL

October 26, 1987

William L. Roper, M.D., Adm.
Department of Health & Human Services
Health Care Financing Adm.
Washington, D.C. 20201

Dear Mr. Roper:

Thank you for the opportunity to respond to the mortality statistics for calendar year 1986 prior to public disclosure. Our chief executive office and medical staff leadership have reviewed the report and find that the majority of the data is accurate, however, does not take into consideration the entire Medicare population treated at this facility.

St. Frances Cabrini is a 304 bed not-for-profit acute care facility and is a member of the Sisters of Charity of the Incarnate Word Health Care System. Our patient population is comprised of many people with serious medical and surgical illnesses. We offer a full range of medical care services and our mission is to offer care to all people in need, with an emphasis on the indigent and the elderly, with a large number of our patients being Medicare beneficiaries. A large number of seriously ill patients whose conditions require continuous care, both inpatient and outpatient, are attracted to our facility by the specialty care offered in the following areas: An open heart surgery program, intensive care services and major programs such as neurosurgery, endocrinology, oncology, lung disease, trauma, stomach and intestinal diseases.

In addition, the expertise of our medical staff and the advanced technologies we offer to the community combine to make us a major referral center for this region. Examples of this technology include: Heart catheterization, radiation and chemotherapy, interostomal therapy, invasive vascular diagnostic procedures, inpatient renal dialysis and state-of-the-art life support equipment.

As a not-for-profit health care provider, our mission is to offer an environment of hope, healing and peace to all who seek relief in times of illness and death. Our patients come to us from not only our immediate service area of Rapides Parish but also from outlying rural areas throughout Central Louisiana.

3330 MASONIC DRIVE ALEXANDRIA, LOUISIANA 71301 (318) 487-1122

The medical staff quality assurance program at St. Frances Cabrini Hospital reviews all mortality cases for appropriateness of care. Our hospital plans to incorporate data from this report in our ongoing quality assurance and utilization management program as one of the many elements reviewed to maintain and improve the quality care rendered. The differences in mortality rates between hospitals should not be interpreted as differences in the quality of care. Quality assurance and medical staff peer review activities are an integral part of monitoring the health care delivery system at this hospital.

Sincerely,

Jon C. Hilsabeck
Chief Executive Officer

JCH/par

SAINT FRANCIS MEDICAL CENTER
P.O. BOX 1901
MONROE, LA 71201-1901
(318) 362-4000

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. BOX 26684
Baltimore, Maryland 21207

RE: 1986 Mortality Statistics

Thank you for this opportunity to respond to the release of data on hospital mortality rates for 1986. Since receiving the report dated September 21, 1987, St. Francis Medical Center staff has had an opportunity to review the data and ask that the following be added to the final public release:

"St. Francis Medical Center is a 465 bed acute care center located in Monroe, Louisiana. As the regional referral center for an 11 parish area in Louisiana, two west central Mississippi counties and three southeast Arkansas counties, many of St. Francis' patients represent the most severe cases to be found in the area, often transferred from other area hospitals. Of our total discharges over 30% are emergency admits with a large percentage being transferred from other facilities. While the HCFA findings, in its own words does not 'deal with complex issues such as severity of illness, ' we are pleased with the overall ratings, which coincide with our own data.

"It appears surgical procedures are irrelevant to the groupings listed. A prime example is HL- Low Risk Heart Disease. One of the patients included received triple vessel bypass surgery, a high risk procedure. St. Francis believes that future mortality statistics should reflect the procedures that are involved; as major operative procedures definitely alter intensity of care."

"SFMC is the heart center for Northeast Louisiana. In that capacity we do treat the seriously ill cardiac patient in that we are the only facility in Northeast Louisiana that offers cardiac catheterization, angioplasty, and open heart surgery with an on staff cardiac team."

SAINT FRANCIS MEDICAL CENTER
P.O. BOX 1901
MONROE, LA 71201-1901
(318) 362-4000

"Finally, we note that this data is not all inclusive and only reflects the medicare patient who is generally the older more seriously ill individual."

St. Francis appreciates the opportunity to comment prior to publication and is proud that, in general, the HCFA's findings confirm our own ongoing monitoring programs. Even without condiseration of the severity of illness, St. Francis rates well within or below the HCFA range of predicted mortality rates. St. Francis Medical Center is committed to excellence and our primary goal is quality care to all patients.

Sincerely,

Sister Anne Marie Twohig
Chief Executive Officer
St. Francis Medical Center

cc: Bob Hammack

ST. HELENA PARISH HOSPITAL

BOARD OF COMMISSIONERS
ESTELLE ADAMS
BETTY LEE
JOE LOMBARDO
JOE OVERTON
GARY VARNADO
JULIA WILLEY

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for 1986 relative to St. Helena Parish Hospital. Our staff has carefully reviewed and validated the accuracy of the data. Our facility is a 35 bed general medical and surgical hospital serving the residents of St. Helena Parish. Adjacent to the hospital is a 72 bed nursing home. Consulting general surgeons and urologists perform both inpatient and outpatient surgeries. In addition, endoscopies are performed by consulting internists.

Part of our newly established quality assurance program encompasses mortality review. This review is performed to monitor the quality of medical/surgical management provided and insure the highest standard of care for each patient.

In reference to the actual mortality rates, our facility was within the predicted ranges for all categories except cancer. One 85 year old patient expired as a result of breast cancer with generalized metastases and multiple systems failure. She was diagnosed in June 1978 with breast cancer which gradually metastasised throughout her body. She also had chronic urinary tract infections.

I appreciate this response time prior to the December mortality data release.

Sincerely,

Johnnie S. Byrd
Administrator

Attachment

BOX 337 ● GREENSBURG, LOUISIANA 70441 ● PHONE 222-6111

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

STERLINGTON MEMORIAL HOSPITAL
P.O. Box 567
Sterlington, Louisiana, 71280

October 10, 1987

William L. Roper, M.D.
HCFA
Dept of Health & Human Resources
Washington, D.C.

RE: Mortality information for STERLINGTON MEMORIAL HOSPITAL Provider #190178

Dear Sir:

The following is a response to the report on Medicare mortality:

I. The 309 cases, as listed by HCFA, does not include the total number of medicare cases treated in 1986 at Sterlington Memorial Hospital, therefore is not reflective of the true overall picture. This report addresses only those designated diagnostic categories as chosen by HCFA for review and report. The actual total of Medicare patients treated at STERLINGTON MEMORIAL HOSPITAL in 1986 was 672. The total medicare deaths for 1986 was 53, which includes deaths treated as inpatients, long-term care patients, and those who expired 30 days after discharge.

II. The average medicare age of patients admitted to Sterlington Memorial Hospital is 76, therefore these patients will definitely be a high risk group. Approximately 50% of all medicare patients treated at Sterlington Memorial Hospital are nursing home patients who have chronic diseases and/or conditions, and come into the hospital only when the severity of the their condition demands admission. This report also includes patients who expired up to 30 days after discharge, either at home or in the nursing home, which may be attributed to a different diagnosis other than that which the patient was treated for in the hospital. Upon our verification of this report, it was found that five cases listed as expiring after discharge, actually expired in the hospital.

III. All cases were put into categories according to primary reason for admission. The cause of death did not appear to be listed in the appropriate categories on the HCFA mortality report.

IV. In category HS (severe acute heart disease) showing 100% mortality, all of these patients died with a diagnosis of acute myocardial infarction (heart attack). The 4 cases ranged from 79 to 98 years of age. All four cases had multiple complications such as congestive heart failure, renal diseases, diabetes mellitus, and pneumonia. A brief explanation of each case is listed below:

#A. A nursing home patient 79 years of age with recent admission with multiple complications. Family requested patient not be placed on any life sustaining apparatus. The patient expired 2 days after admission,

#B. A nursing home patient 85 years of age who expired 6 days after admission to Swing Bed Unit (skilled unit). The patient was treated as inpatient initially for 12 days for the myocardial infarction (heart attack) and then transferred for terminal care into the Swing Bed (skilled unit).

#C. A nursing home patient 98 years of age with multiple diagnoses, admitted unconscious with probable myocardial infarction (heart attack) and expired within 2 days after admission.

#D. A nursing home patient, 85 years of age, expired less than 24 hours of admission. The patient was admitted in terminal condition.

On extensive study and review, it was found that all four of the above-listed cases were felt to be terminal by all members of the medical staff on routine review of all deaths.

It is felt with the ages and severity of complications that these patients were given the benefit of the optimal level of care, and all of these factors should be taken into consideration upon review of this report.

Sincerely yours,

Larry A. Jones, Administrator

Thibodaux General Hospital

HOSPITAL SERVICE DISTRICT No. 3
WARDS 1, 2, 5, 6
LAFOURCHE PARISH
THIBODAUX, LOUISIANA

COMMISSIONERS:
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DR. PAUL T. GAUDET
JOHN F. PUGH
WHITNEY C. MARTINEZ
JOEL J. CHAMPAGNE
SECRETARY

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

This letter is in response to the HCFA Mortality Data for our Hospital.

Thibodaux General, in operation since 1930, is a 149-bed general, acute care hospital located in the Houma-Thibodaux MSA. However, we are the only hospital in Thibodaux. About 50,000 people live in our general service area. There are other hospitals serving some of this population. Thibodaux General is heavily surgery-oriented. Besides in-patient care, other services provided by us are Skilled Nursing, Home Health, Cardiac Rehabilitation, Ambulatory Surgery, and Emergency.

Your information provided to us is completely accurate. People involved in the evaluation were the Utilization Review Physician, the Chief of Staff, the Administrator, the Business Office Manager/DRG Co-ordinator, and the Medical Record Administrator.

Other than the basic information you provided, the following types of information were also gathered for evaluation: diagnostic category, risk factor, Diagnostic Related Group description, admitting Doctor, attending Doctor, admit source, place to which discharged, and number of times admitted in 1986. For those patients who did not die in the hospital, contact was made with nursing homes and/or Doctors' offices to determine cause of death.

All of our mortality percentages were well within the range of predicted mortality rates. However, we wish to make several statements which we feel are of significance when looking at mortality data.

1. There are three nursing homes in Thibodaux, representing a total of 302 beds. Frequently, these homes have waiting lists.

2. Besides ours, there is one other Home Health Agency in Thibodaux.

3. Thibodaux is located in the southeastern part of the State which has the highest cancer rate in the nation. Of the diagnostic categories selected for your data, more of our patients died from cancer than any of the other categories. Six of the seventeen cases were diagnosed as terminal upon being admitted.

P.O. BOX 1118
THIBODAUX, LA 70302-1118

504 447-5500

602 N. ACADIA ROAD
THIBODAUX, LA 70301

4. Using your classifications, 86 of the 119 patients were considered high risk, or 72%.

5. The average age of all patients in this release was 77 and of the 119 patients, 67 were 77 years of age and over, or 56%.

6. 64 patients had one or more other admissions than the one of their death during 1986, or 54%.

7. 56 patients had complications besides the basic diagnosis, or 47%.

8. The Medical Staff, through the Chief of each service, conduct monthly reviews of each death reported for the particular service to evaluate the medical management and overall care of such patients. In this way, any patterns of possible inappropriate care can be detected and brought to the attention of the Staff or the individual Physician.

9. Quality Assurance, by the Medical Staff and by the employees, is a major function done in our Hospital. Utilization Review is also very significant here.

10. Thibodaux General is proud to be accredited by the Joint Commission.

We appreciate the opportunity you have afforded us to comment on our own mortality data. Hopefully, the statements made will be of help in understanding how the 119 patients in this data release were generally in a high acuity level of illness.

Should there be any questions about any of our comments, please contact the Administrator.

Respectfully yours,

THIBODAUX GENERAL HOSPITAL

Donald L. Peltier, Chairman of the Board

John Wesley Magee, III, M.D., Chief of Staff

Joel J. Champagne, Administrator

DLP/JWM/JJC:dfg

TOURO

INFIRMARY

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Statistics
Calendar Year 1986

Dear Administrator:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for calendar year 1986. Since receiving the report, the Touro Infirmary staff has had an opportunity to review the data.

Of Touro's total admissions in 1986, 41% were Medicare patients. Overall, the Touro mortality rates are all well within the predicted ranges. They are below the national average in 12 of the 16 diagnostic categories and at the national average in two. In those categories in which Touro was below the national average, the difference ranged from as much as 10% less in two high risk areas and 40% less than the national average in a low risk category.

In checking our data, it was determined that 18.8% (63 cases) of the reported deaths occurred outside Touro. The actual in-house mortality rates of the reported statistics is 8.9%.

A full-service, not-for-profit 564-bed medical center, Touro offers a complete range of medical and surgical services embracing both primary and tertiary care. Its medical staff is composed of 600 physicians representing every major medical and surgical specialty and sub-specialty. Three-fourths of Touro physicians hold teaching appointments at Louisiana State University and Tulane medical schools.

Touro is fully accredited by the Joint Commission on the Accreditation of Hospitals and is a member of the American Hospital Association, the Louisiana Hospital Association, the Metropolitan Hospital Council of New Orleans, the Council of Teaching Hospitals of the Association of American Medical Colleges and Premiere Hospitals Alliance, Inc.

1401 Foucher Street • New Orleans, Louisiana 70115-3593 • 504-897-7011

Specialty services Touro provides include comprehensive inpatient and outpatient medical rehabilitation; complete coronary care, including cardiac rehabilitation; diabetes management and education; comprehensive cancer diagnosis, screening and treatment programs; a center for chronic pain and disability rehabilitation; a psychiatric center; a skilled nursing facility; home health services; a 24-hour emergency treatment center with helicopter service; one day surgery; outpatient diagnosis, treatment and health education; and an osteoporosis screening program.

Of the categories reported, although Touro was well within the predicted ranges, it was slightly above the national average in two categories: cancer and heart. This can be attributed to the extensive programs that Touro offers and the high rate of incidences in these areas.

As noted, Touro's Cardiac program is comprehensive. The Department conducts over 25,000 cardiac procedures annually. Non-invasive diagnostic procedures are emphasized. Also offered are catheterization, angiography and such specialized procedures as pacemaker implantation, coronary angioplasty and intra-coronary thrombolysis.

Heart patients are carefully monitored in Touro's coronary care unit and a cardiac rehabilitation program is offered to those recovering from heart attacks and heart surgery.

Touro has the oldest approved private hospital comprehensive cancer program in the New Orleans area. Cancer programs at Touro include a dedicated Oncology Nursing Unit, an active Radiation Oncology Treatment Unit, an Outpatient Oncology Treatment Unit, Breast Cancer Screening, Education and Rehabilitation Programs, the first Tumor Registry in Louisiana, ongoing support groups, weekly cancer conferences, a continuing series of cancer education lectures, periodic educational seminars and screenings for the public. Touro's Cancer Program was surveyed by the American College of Surgeons in early 1987 for the years 1983-86 and has received another three year approval. Touro has been continuously approved in this category since the accreditation process was begun in 1973.

It should be noted that the incidence of some kinds of cancer is higher in Louisiana and, specifically, South Louisiana than other parts of the nation. Louisiana has, for example, the highest mortality rate in the nation for white males with lung cancer. And Black males from New Orleans have the highest incidence of lung cancer in the world. Urinary bladder cancer also has excessive mortality rates in Southern Louisiana.

The average age of cancer patients and the stage of the disease at the time of diagnosis were also high at Touro in 1986. Examples are as follows:

Site of Cancer	Aver. Patient Age at Diagnosis	Stage at Diagnosis
Bladder	68	47%, Stage I & Beyond (25%, Stage III,IV)
Breast	61	44%, Stage II & Beyond (16%, Stage III,IV)
Colon	70	74% Stage II & Beyond (54% Stage III, IV)
Lung	69	72%, Stages II & III (No Stage IV for lung cancer)
Prostate	72	49%, Stage II & Beyond (44%, Stages III & IV)

Touro has a self-monitoring mortality program that is strictly adhered to. A 100% mortality review is performed on an ongoing basis by Touro's Medical Staff Departmental Quality Assurance Subcommittees. In addition, mortality reviews are performed by the Surgical department's bi-monthly conferences that include Death Summary and Complications.

Again, thank you for the opportunity to review the data.

Sincerely,

Ruth D. Zamora

Ruth D. Zamora
Director of Operations

TULANE MEDICAL CENTER HOSPITAL AND CLINIC

1415 TULANE AVENUE NEW ORLEANS, LA 70112

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D. C. 20201

Dear Dr. Roper:

Thank you for the opportunity to comment on the mortality information you have prepared on Tulane Medical Center Hospital.

Tulane Medical Center Hospital is a 300 bed acute care facility, a university teaching hospital offering a wide range of specialty and subspecialty care, including oncology, cardiac services, major orthopaedic service, dialysis and renal transplantation, as well as pediatrics, general medicine, surgery and psychiatry.

The staff of Tulane Medical Center Hospital have carefully reviewed the specific mortality data provided. This review has included the Chief of Staff, Medical Director of Quality Assurance, hospital administrative staff, Director of Case Management and Administrative Associate for Quality Assurance and Utilization Review.

Of note, with regard to the structure of this report, is the pulmonary category. Although designated as a high risk category, it apparently groups all pneumonias, pulmonary emboli, etc. together. It is conceivable, therefore, that facilities treating many simple pneumonias, for example, could have a very low mortality rate while those facilities with a higher incidence to complicated pulmonary diagnoses would demonstrate a much higher rate and range.

The information prepared by the health care institutions and used by Health Care Financing Administration in its mortality study was not originally intended for this purpose. It is therefore questionable whether or not the database driving the regression model is necessarily accurate in this instance.

We feel it necessary to state, unequivocally, that mortality is an insufficient and inaccurate indicator of the quality of care delivered by an institution. This is particularly true when we consider that the elderly,

about whom the present data are concerned, have inherently less ability to fight the effects of disease and injury and a far greater susceptibility of combinations of disease.

Tulane Medical Center Hospital's staff and physicians, as has been our practice, will continue to review intensely every patient's death for quality and appropriateness of care. While we recognize death as the inevitable outcome of life itself and as the inevitable consequence of the many combinations of age and specific diseases and injuries in patients we are called on to treat, we have not and never will accept anything less than a vigorous fight to protect life and human dignity.

Sincerely,

Charley O. Trimble
Vice President for
Hospital and Clinic Affairs

COT/dh

UNION GENERAL HOSPITAL
901 JAMES AVENUE
FARMERVILLE, LOUISIANA 71241
PHONE (318) 368-9751

November 4, 1987

Department of Health and Human Resources
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Sir:

I am writing concerning the mortality data for Union General Hospital. In reviewing records of the names submitted, I have found an error credited to our hospital.

The patient, [redacted], a 72 year old male, was transferred from our facility on 4/19/86 to North Monroe Community Hospital where he died. This patient was listed on our hospital's mortality record. Please correct this error.

Also some of the patients listed were transferred to nursing homes where they expired. I feel our hospital should not be credited with these deaths.occurring at another facility.

Please consider these comments before publishing your data.

Sincerely,

Lynette Wade, R.N.

Lynette Wade, RN
Quality Assurance
Union General Hospital
Provider# 190170

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF HOSPITALS
UNIVERSITY MEDICAL CENTER
2390 W. CONGRESS P. O. BOX 4016-C
LAFAYETTE, LOUISIANA 70502
(318) 261-6000
LINC 325-6000

EDWIN W. EDWARDS
GOVERNOR

SANDRA L. ROBINSON, M.D., M.P.H.
SECRETARY

MEDICARE NUMBER - 190006

University Medical Center was within the expected mortality rates in all categories except one. The category, sepsis, involved only four patients. The average age of these four patients was 80. The length of stay for three of the four cases was less than two days. All of the patients had multiple system diseases such as cancer, diabetes mellitus, etc.....in addition to sepsis. All four were comatose upon admission to the hospital. Two other categories, Gastrointestinal catastrophes and Gynecological diseases, which contained two patients each did not have any recorded deaths. No valid conclusions may be drawn from such small samples.

"AN EQUAL OPPORTUNITY EMPLOYER"

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

State of Louisiana

EDWIN W. EDWARDS
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF HOSPITALS
WASHINGTON-ST. TAMMANY REGIONAL MEDICAL CENTER
400 MEMPHIS STREET
P.O. BOX 40
BOGALUSA, LOUISIANA 70427-0040
504/735-1322

SANDRA L. ROBINSON, M.D., M.P.H.
SECRETARY
(504) 342-6711

October 19, 1987

CERTIFIED MAIL AND RETURN RECEIPT REQUESTED

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Medicare Provider No. 190001

Dear Dr. Roper:

The following information is submitted by Washington-St. Tammany Regional Medical Center in response to the mortality information on Medicare patients admitted in 1986.

Washington-St. Tammany Regional Medical Center is a 68-bed primary care facility state-owned and funded for the indigent population of two parishes in Louisiana. Our hospital has 12 physicians on the Active Staff and 10 residents in Family Medicine. Eight members of the Active Staff are Board Certified.

In accordance with the Risk Management/Quality Assurance Program at Washington-St. Tammany Regional Medical Center, the Medical Staff reviews the medical records of patients who expire here using pre-established criteria. During the last survey by the Joint Commission on Accreditation of Hospitals, the Medical Staff was commended for its peer review functions and no recommendations were received from JCAH.

Our hospital's mortality data reported by HCFA has been carefully reviewed by the Hospital Administrator, Utilization Review Coordinator, and Physician Chairman of the Medical Records Committee. The data included three patients whose status needs to be clarified as follows:

[redacted] - Patient is not deceased; admitted to this facility 6-2-87 for surgery and discharged in good condition 6-10-87; seen in outpatient clinic 9-11-87.

[redacted] - Patient transferred 8-1-86 from this facility to Veterans Administration Hospital in New Orleans, LA.

[redacted] - Patient was referred to another hospital on 6-6-86 for radiation therapy.

The mortality data released by HCFA includes Medicare patients who died within 30 days after discharge from Washington-St. Tammany Regional Medical Center.

Please furnish our hospital a copy of HCFA's December Mortality Data Release. Thank you for the opportunity to respond to your data prior to public disclosure.

Sincerely,

Bill Mohon

Bill Mohon
Hospital Administrator

BM/jw

WEST FELICIANA PARISH HOSPITAL

P. O. BOX 368

ST. FRANCISVILLE, LA. 70775

PHONE: (504) 635-3811 BATON ROUGE (504) 343-7242

October 16, 1987

RE: Mortality Statistics
Provider # 190142

The Medical Staff at West Feliciana Parish Hospital conducts an intensive review of the Medical Record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance Program and peer review activities are an integral part of the monitoring of the health care delivery system at this hospital.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrator, physician Chairman of Utilization Review Committee, Medical Director of Quality Assurance and the Director of Medical Records. Our overall percentage of deaths is within HCFA's Range of Predicted Mortality Rates.

Thank you for the opportunity to present this response and please allow us to receive a copy of HCFA's December Mortality Data Release.

We Want You To Know Us ***WELL***

West Jefferson Medical Center

1101 Avenue D • Marrero, LA 70072
(504) 347-5511

David M. Smith, F.A.C.H.E.
Director

Board of Directors:
William Townsend
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Jack L. Winters, M.D.

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Re: Hospital # 190039 Mortality Data

Dear Dr. Roper:

On behalf of our Medical Staff of 280 physicians and the community we serve with a population of over 250,000, we appreciate the opportunity to comment on the mortality rates for our institution. We understand the purposes that HCFA is trying to achieve by the simulation of predicted mortality rates to actual mortality rates by institution within a region, state and nationally. Due to the many facets of treating patients for their illnesses we hope that HCFA will not be negligent in reporting these rates without reflecting the acuity as well as the diversity of services in providing quality care for the ultimate outcome of patient satisfaction and better health.

Our facility is licensed for over 400 beds which are for the treating of patients with acute conditions. Some of the services this institution offers to the immediate community and to outlying referring facilities are: Burn Unit; Percutaneous Transluminal Coronary Angioplasty Lab; Coronary Bypass Services; Oncology; Intensive Care, Coronary Care, and Surgical Care Specialty Units; Renal Dialysis; and a Medical Emergency Helicopter Service. We are considered a referral institution for outlying facilities within 75 miles, and with our emergency helicopter services have the capability of receiving patients from outlying facilities up to 200 miles away.

As a non-profit healthcare facility, our doors are open to all types of patients. We have a very busy emergency room staffed 24 hours a day by physicians, and 1/3 of our inpatients are admitted to the hospital through this service. We also provide home care for chronically and terminally ill patients. In reviewing the sixteen diagnostic categories in which mortality rates were computed our facility's actual rate was within the range of predicted mortality rates as computed by HCFA's statistical model. The majority of our actual rates fell within the mean averages except for two high risk categories (Pulmonary Disease and Severe Acute Heart Disease).

Our Medical Staff representatives and Quality Assurance personnel investigated all deaths identified in the HCFA data release. Specifically our analysis included appropriateness and quality of care provided, with focus on any patterns or trends; no trends were identified.

The Pulmonary Disease diagnostic category was the first category reviewed. Since this category's actual rate was substantially below the mean (a favorable variance) we limited our analysis of these records to any trends and physician practice patterns relative to high risk pulmonary disease patients. Of these fifteen charts reviewed, one expired at home, and another expired in our Skilled Nursing Facility; the remaining patients expired during their last hospital admission. Our physician reviewers found no significant variance nor any patterns or trends identified in the care provided to these fifteen patients.

The second category reviewed pertains to the severe acute heart disease diagnostic cases. This category consisted of forty-three patients who expired, while the mean indicated a predicted mortality of forty such occurrences. In reviewing these cardiac records our physician reviewers found no patterns nor trends. Twenty-five of these patients were over 70 years of age. The cases included diagnosis of acute myocardial infraction, cardio pulmonary arrest and cardiogenic shock. With our medical emergency helicopter service we received patients from hospitals in outlying areas that are not able to provide the full complement of cardiac services. Also, in this period of time, we increased the number of cardiologists and open heart surgeons on our medical staff, and therefore, we were able to care for more cardiac patients who were sicker than the predicted norm.

Of all the diagnostic categories provided in HCFA's data it is interesting to note that the actual mortality rate of this institution was 12%, whereas the range of predicted mortality was 9%-16% with a mean rate of 13%. Therefore, based on the patient mix of disease categories this institution's mortality rate was favorable to the predicted rate.

Our hospital and medical staff are committed to providing the best quality of medical care to all patients. Standing medical staff committees regularly address the quality of care that all patients receive. One of the many functions of the Quality Assurance Committees is the review of all patient mortality records. All cases in the report were reviewed previously by the respective committee of physicians for quality and appropriateness of care. Of the number of cases identified by HCFA, 14% of all deaths occurred after the patient was discharged and this institution has no way of reviewing the cause of death nor the setting in which care was being provided. We believe that our monitoring system provides us with a continuous feed back mechanism in our effort to meet and exceed quality care standards. Every death which occurs in this facility follows a mandatory review process. Our reviewing process was praised by the Joint Commission on Accreditation of Hospitals during their last inspection, after which this hospital was awarded the maximum accreditation period of three years.

In closing, we would like to reiterate the fact that the data to be released by HCFA do not reflect the severity of illness of the patient, nor the cause of death of the individual, which may be unrelated to the cause of last admission into the hospital. A patient death is seldom the result of poor quality care. Death is not an all inclusive indicator of the quality of

care received by the patient. The mortality data by HCFA doesn't identify areas in which the hospital provides high quality or low quality care or otherwise measure hospital performance. Comparisons of actual and predicted mortality rates may only suggest that the hospital and it's medical staff review an area to determine if a quality problem does exist. It is also interesting to note that the state peer review program which works for HCFA has not identified one incidence of questionable quality care provided to any Medicare beneficiaries over the last three years: a Medicare patient population exceeding 15,000 patients. This mortality rate was based off a Medicare population which included only 55% of annual Medicare patients treated, which the majority fell into the high risk diagnostic categories for this study and expired up to 30 days after hospital discharge.

We hope that any evaluations of HCFA's data pertaining to this institution, whether at a local, state, regional or national perspective will consider the severity of illness of patients treated, source of patient transfer, and whether the patient had a terminal illness.

Sincerely,

WEST JEFFERSON
MEDICAL CENTER

Patrick Stumpf, M.D.
President - Medical Staff

William Townsend
Chairman,
Board of Directors

David M. Smith, FACHE
Medical Center Director

eme

AMI Westpark Community Hospital

October 22, 1987

Dr. William L. Roper
Health Care Financing Administrator
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of mortality data for January 1, 1986 - December 31, 1986.

AMI Westpark is an 80-bed, acute care facility located approximately 45 minutes from New Orleans. Our patient population is primarily Medicare, dealing with major medical and surgical illnesses.

Mortality review is an ongoing quality assurance function of the Medical Staff and is an integral part of the ongoing monitoring of the health care delivery system at AMI Westpark Community Hospital. We believe that this monitoring system provides us with a continuous feedback mechanism to review, analyze, and upgrade our quality-of-care standards relative to patient care.

The statistics regarding the mortality data for Westpark have been validated for accuracy and, with one exception, are felt to be appropriate. This information has also been reviewed by the administration of the hospital and the Medical Staff Executive Committee.

Again, thank you for the opportunity to respond to this data.

Sincerely,

Harry D. Provost, Jr.
Executive Director

HDP/z

WILLIS-KNIGHTON MEDICAL CENTER

James K. Elrod
President

October 26, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Balitmore, Maryland 21207

Dear Dr. Roper:

The following information for Willis Knighton Medical Center(Provider number 190111) is to be attached to the Hospital Specific Report for the period of January 1, 1986 through December 31, 1986 prior to public disclosure.

Willis Knighton Medical Center is a 426 bed acute care facility whose case mix includes many patients with major medical and surgical illnesses. We are a full service medical center offering care in speciality areas of oncology, open-heart surgery, major orthopedic services, rehabilitative medicine, dialysis, ophthalmology as well as general medicine and surgery. Willis Knighton Medical Center's first and foremost commitment is to provide high quality care.

The Medical Staff at Willis Knighton Medical Center conducts an intensive review of the medical record of every patient who expires at this facility regarding the medical management and overall care of each of these patients. Mortality review is an on-going process by our Quality Assurance program and our Medical Staff, along with additional monitors to assure our patients the best quality of care. Willis Knighton Medical Center has met all accreditation standards set by the Joint Commission of Accreditation of Healthcare Organizations for our Quality Assurance program and the Medical Staff Peer Review process. In achieving these standards Willis Knighton Medical Center has been accreditated for the full three year period.

The Hospital Specific Mortality Data reported by the Health Care Financing Administration has been carefully reviewed and it was noted that all actual mortality rates as determined by the study fell well within the study's predicted mortality ranges established for this facility.

This Hospital Specific Mortality Data is not but one of many indicators of the quality of care rendered by Willis Knighton Medical Center. This Mortality Data alone is not by any means a report card that reflects the total quality of care administered at our facility.

The Quality Assurance program and the Medical Staff of Willis Knighton Medical Center will continue to review every mortality case for quality and appropriateness of care along with our additional monitors to promote the optimal quality of care for patients treated at our facility.

Thank you for the opportunity to present this response.

Sincerely,

James K. Elrod, President
Willis Knighton Health Systems

Hoyet Chance, M. D.
Chief of Staff
Willis Knighton Health Systems

CERTIFIED MAIL/RETURN RECEIPT

October 20, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

The following information for Woman's Hospital is to be attached to the Hospital Specific Report for 1986.

Woman's Hospital is a 165 bed acute hospital which specializes in obstetrics and gynecology and neonatal care. We offer a full range of care to patients who need these services, including the services of an gynecologic oncologist, two neonatologists and perinatal consultation.

The Hospital specific mortality data reported by HCFA has been carefully reviewed by the Hospital administration, representatives of the Medical Staff including the Chief of Staff, the Director of Quality Assurance and the Director of the Medical Records Department. The Hospital had no medicare patients who died during the reporting period within the parameters of the data reported (during hospitalization or within 30 days of admission). We consider this to be only one measure of the excellent care provided at Woman's Hospital.

Woman's Hospital has an established quality assurance program which includes review of the medical record of every patient who dies, is transferred, or has any outcome which would not be considered appropriate to the care given. This review occurs concurrently and continuously as part of the peer review process of the Hospital.

The Medical Staff of Woman's Hospital will continue to review all deaths and other specific conditions of morbidity for quality and appropriateness of care given to all Woman's Hospital patients. This analysis is helpful in identifying opportunities to improve care.

Sincerely yours,

Thomas R. Hightower

Thomas R. Hightower
Administrator

WOMAN'S HOSPITAL
Thomas R. Hightower, [illegible]

Airline Highway at Goodwood Boulevard
P.O. Box 95009
Baton Rouge, Louisiana 70895-9009 (504) 927 1300
LA 163

WOODVIEW REGIONAL HOSPITAL

5505 SHREVEPORT HIGHWAY • PINEVILLE, LOUISIANA 71360 • (318) 640-0222

October 27, 1987

William L. Roper, M.D.
The Administrator
Department of Health and Human
Services
Health Care Financing Administration
Washington, D.C. 20201

Re: Medicare Mortality Information - Medicare Provider Number 190179

Dear Dr. Roper:

We received your letter containing Medicare Mortality Information. We have honored both of your requests. That is, we are not sharing this information, and we have not contacted any families for follow up.

On review of your patient list and diagnostic categories, we found two (2) patients that should be reclassified. The first, [redacted] showed a principal diagnosis of 427.5 and should be 578.9. Secondly, patient [redacted] is coded 4275 and should be coded 436. Please make these two corrections in your data and mortality statistics.

Our comments for public release are included on a separate sheet of paper. We thank you for the opportunity to provide comments on this data, and that our comments will be published.

Sincerely,

Robert R. Bash
Administrator

RRB:jl

cc: Gary DePew
National Healthcare, Inc.

encl

WOODVIEW REGIONAL HOSPITAL

5505 SHREVEPORT HIGHWAY • PINEVILLE, LOUISIANA 71360 • (318) 640-0222

October 27, 1987

PUBLIC INFORMATION RELEASE

MEDICARE MORTALITY INFORMATION

Medicare Provider Number 190179

Woodview Regional Hospital believes that mortality statistics and quality of care have no discernible connection at this time. That is, there is no indication that mortality statistics are an indicator of quality care. Rather, it appears that referral patterns, types of patients treated by individual physicians, and other factors are more important in determining the mortality statistics of a hospital than the hospital's quality of care. With that preface in mind, we will comment on the mortality rates that the government insists on publishing. Overall, Woodview experienced a nine percent mortality rate from the elderly Medicare patients where the "expected range" varies from seven to seventeen percent. Thus, overall, our actual mortality rate was very low. Although our mortality rate is very low, and we are happy that it is low, and we think we have a high quality of care; we reiterate that we do not think this mortality rate is an indicator of quality of care.

Our medicare cases are broken into sixteen diagnostic categories. In all of these categories, except three, our mortality rate is within the range of predicted mortality rates. Of the three diagnostic categories not in the predicted range, two are slightly above the range and one is below the range. The two categories above the predicted range include one category with three cases and one category with one case. We believe these numbers to be too small to give an accurate statistical picture. The same is true of those categories below the expected range.

Our hospital, both physicians and hospital employees, is dedicated to providing quality care. Our commitment to serve the physician and his or her patients with the best possible service and quality of care continues.

Maine

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
BATH MEM HOSP BATH ME 04530	ME-5	378	12	8-17	26	8	7-39	17	35	13-55	8	13	2-55	22	5	9-44	24	33	17-54	14	7	6-49	34	29	9-38						
BLUE HILL MEM HOSP BLUE HILL ME 04614	ME-6 *	321	12	10-19	30	30	19-53	6	17	9-74	13	15	6-51	28	29	11-42	8	13	13-73	6	17	3-65	38	18	11-38						
CALAIS REGIONAL HOSP CALAIS ME 04619	ME-7 *	376	16	12-22	14	64	11-57	12	42	12-62	11	36	4-52	32	16	13-43	34	38	26-59	11	9	2-49	50	22	14-39						
CARY MEDICAL CENTER CARIBOU ME 04736	ME-8 *	657	10	8-15	47	17	12-39	22	32	14-51	12	17	7-55	33	21	11-40	22	50	18-57	17	12	7-47	52	13	10-33						
CASTINE COMM HOSP CASTINE ME 04421	ME-9 *	56	13	10-31	2	50	2-89	3	33	3-82	1	0	2-99	4	50	6-81	3	0	7-88	2	0	4-93	11	9	5-52						
CENTRAL MAINE MED CTR LEWISTON ME 04240	ME-10	1819	12	9-16	152	36	21-40	72	31	18-39	29	21	8-39	86	23	14-33	77	44	26-49	51	16	10-36	101	7	12-30						
CHARLES A OEAN MEM HOSP GREENVILLE JUNCTION ME 04442	ME-11 *	104	16	8-23	4	75	2-75	5	20	4-72	4	25	0-76	5	20	3-70	7	29	13-76	2	50	4-92	20	20	7-42						
DOWN EAST COMMUNITY HOSPIT MACHIAS ME 04654	ME-12 *	366	14	11-20	15	33	11-55	14	36	12-58	12	33	5-51	27	30	12-44	22	23	21-61	7	43	8-70	62	16	13-36						
EASTERN MAINE MED CTR BANGOR ME 04401	ME-13 *	2597	12	10-17	257	21	20-36	119	23	20-38	43	19	9-35	106	30	16-33	134	38	30-48	29	24	9-42	143	20	15-30						
FRANKLIN CO MEM HOSP FARMINGTON ME 04938	ME-14 *	796	10	10-17	48	27	16-43	23	43	14-50	16	13	4-42	41	15	14-40	45	33	27-56	37	5	6-33	70	17	11-32						
HENRIETTA O GODDALL HOSPIT SANFORO ME 04073	ME-15 *	741	11	10-18	68	29	13-36	28	11	13-46	9	22	3-54	42	17	12-38	57	39	28-55	8	0	2-57	67	13	11-32						
HOULTON REGIONAL HOSPITAL HOULTON ME 04730	ME-16 *	498	10	9-18	28	18	10-43	22	27	12-49	10	30	2-50	29	17	9-39	28	29	21-56	30	17	10-42	72	8	9-29						
JAMES A TAYLOR HOSP BANGOR ME 04401	ME-17 *	182	14	10-23	12	8	12-62	5	20	7-76	5	20	1-68	10	20	6-56	9	33	13-70	4	0	1-74	41	27	10-36						
KENNEBEC VALLEY MED CTR AUGUSTA ME 04330	ME-18	1502	13	9-16	149	29	16-34	50	20	16-42	37	11	9-37	66	30	15-36	81	40	27-49	19	11	4-40	144	24	13-28						
MAINE COAST MEM HOSP ELLSWORTH ME 04605	ME-19 *	607	13	9-17	51	22	9-33	24	50	14-50	34	3	8-36	35	17	16-46	17	24	20-65	6	17	2-64	65	22	13-34						
MAINE MEDICAL CENTER PORTLAND ME 04102	ME-20 *	4255	10	9-15	424	22	18-32	104	21	20-38	67	18	9-30	172	24	17-30	222	32	29-44	53	4	9-33	225	16	13-27						
MAYO REG HOSP HAD 4 DOVER-FOXCROFT ME 04426	ME-21 *	653	11	8-16	30	27	10-42	22	41	14-51	20	25	4-38	29	24	13-44	21	29	18-58	12	33	5-52	91	11	11-29						
MERCY HOSPITAL PORTLAND ME 04101	ME-22	1697	11	9-15	161	19	13-30	55	25	19-44	36	17	7-34	85	34	15-34	70	46	29-53	25	12	5-37	174	13	12-26						
MID-MAINE MEDICAL CENTER WATERVILLE ME 04901	ME-23 *	1774	12	10-17	154	20	19-37	49	24	19-46	29	14	7-38	116	23	16-33	89	44	30-51	42	31	12-41	97	20	13-31						
MILES MEMORIAL HOSP DAMARISCOTTA ME 04543	ME-24 *	415	12	10-19	32	25	12-43	16	19	12-55	11	9	4-52	31	13	11-41	19	11	19-61	8	63	11-71	51	24	12-36						
MILLINOCKET REGIONAL HOSP MILLINOCKET ME 04462	ME-25 *	293	10	8-17	13	31	11-58	10	30	9-62	11	9	4-51	17	24	10-51	6	17	11-77	8	13	2-56	43	12	9-33						
MT DESERT ISLAND HOSP BAR HARBOR ME 04609	ME-26 *	519	11	10-18	35	37	16-47	11	9	9-59	12	8	5-51	38	16	12-39	22	32	24-63	15	20	5-47	71	14	12-3						
NORTHERN CUMBERLAND MEMORI BRIDGTON ME 04009	ME-27 *	505	12	8-16	16	19	8-50	15	33	10-53	4	25	1-75	35	17	10-37	20	55	20-61	19	16	11-52	43	14	9-33						
NORTHERN MAINE MED CTR FORT KENT ME 04743	ME-28 *	420	14	10-19	21	38	13-51	11	9	8-58	13	15	6-51	20	20	8-45	19	74	23-65	7	29	4-64	67	15	12-33						
OSTEOPATHIC HOSP OF MAINE PORTLAND ME 04101	ME-29 *	1239	13	10-17	89	37	19-40	42	17	16-43	15	27	6-47	74	30	14-34	47	45	26-54	46	11	10-36	121	18	13-29						
PARKVIEW MEMORIAL HOSPITAL BRUNSWICK ME 04011	ME-30 *	372	7	8-17	7	14	5-65	7	14	6-66	14	14	7-51	35	17	11-39	12	33	20-72	16	13	5-45	31	16	10-40						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BATH MEM HOSP BATH ME 04530	1	100	1-97	3	33	3-83	18	11	1-32	6	0	0-100	37	5	0-18	8	0	0-68	2	0	0-100	31	6	1-20	19	5	0-35
BLUE HILL MEM HOSP BLUE HILL ME 04614	2	0	1-90	2	0	2-90	2	0	0-99	4	0	0-100	40	3	1-18	8	13	0-61	7	0	0-86	28	7	1-22	3	0	0-100
CALAIS REGIONAL HOSP CALAIS ME 04619	2	50	3-92	11	55	16-70	1	0	0-100	.	.		46	2	2-18	6	33	0-63	2	0	0-100	40	0	1-17	8	13	0-55
CARY MEDICAL CENTER CARIBOU ME 04736	2	0	1-90	2	0	3-91	10	10	1-47	9	0	0-99	69	4	2-14	52	4	1-17	7	0	0-100	58	3	2-16	39	3	0-18
CASTINE COMM HOSP CASTINE ME 04421	1	0	0-97	.	.		1	0	0-100	.	.		6	17	0-64	1	0	0-97	.	.		6	0	0-71	2	0	0-98
CENTRAL MAINE MED CTR LEWISTON ME 04240	12	25	9-61	19	21	18-61	59	8	6-24	15	0	0-87	177	6	2-10	78	1	1-14	13	0	0-99	174	7	2-9	133	1	0-7
CHARLES A OEAN MEM HOSP GREENVILLE JUNCTION ME 04442	2	100	1-90	1	0	1-97	1	0	0-98	.	.		4	0	0-80	3	0	0-98	.	.		10	10	0-50	5	0	0-99
DOWN EAST COMMUNITY HOSPIT MACHIAS ME 04654	.	.		4	25	6-81	15	7	1-37	.	.		20	5	0-29	6	0	0-70	.	.		32	6	1-21	17	0	0-60
EASTERN MAINE MED CTR BANGOR ME 04401	28	21	8-45	11	55	18-72	97	5	5-19	3	0	0-100	207	6	4-11	86	0	1-14	25	0	0-34	194	6	3-10	198	1	0-5
FRANKLIN CO MEM HOSP FARMINGTON ME 04938	7	14	7-70	5	0	4-72	26	12	3-30	1	0	0-100	78	3	2-15	39	0	1-20	4	0	0-100	73	1	2-14	55	2	0-12
HENRIETTA D GOODALL HOSPIT SANFORD ME 04073	7	57	6-68	15	7	14-60	19	0	2-32	9	0	0-100	80	3	1-12	12	0	0-43	11	9	0-98	79	1	2-13	49	2	0-14
HOULTON REGIONAL HOSPITAL HOULTON ME 04730	2	0	2-91	5	40	4-73	12	8	1-42	1	0	0-100	43	2	1-18	27	4	0-25	7	0	0-100	43	7	1-17	21	0	0-40
JAMES A TAYLOR HOSP BANGOR ME 04401	2	50	2-90	2	0	3-91	.	.		.	.		20	10	1-29	9	0	0-51	1	0	0-100	15	0	1-35	6	0	0-89
KENNEBEC VALLEY MED CTR AUGUSTA ME 04330	8	50	11-72	5	60	7-77	55	9	4-21	6	0	0-100	152	4	2-10	69	1	1-15	24	0	0-59	102	3	2-11	94	3	0-8
MAINE COAST MEM HOSP ELLSWORTH ME 04605	3	33	9-90	10	50	14-69	18	0	2-35	2	0	0-100	71	7	1-13	28	0	0-24	6	0	0-100	45	2	1-16	32	3	0-24
MAINE MEDICAL CENTER PORTLAND ME 04102	54	9	8-38	29	45	25-62	128	9	4-15	40	0	0-31	306	6	3-10	157	1	1-11	44	0	0-54	647	6	4-8	296	2	0-4
MAYO REG HOSP HAD 4 DOVER-FOXCROFT ME 04426	9	33	5-60	7	29	9-71	23	9	2-29	3	0	0-100	77	0	2-14	10	10	1-47	7	0	0-65	48	2	1-15	86	2	0-9
MERCY HOSPITAL PORTLAND ME 04101	6	50	6-72	10	30	13-68	53	9	3-21	9	0	0-100	184	4	2-10	109	1	1-12	18	0	0-86	99	2	2-11	140	1	0-6
MID-MAINE MEDICAL CENTER WATERVILLE ME 04901	12	25	6-56	32	47	23-59	53	9	7-27	38	0	0-24	181	5	3-11	89	0	1-13	14	0	0-77	149	2	2-10	81	0	0-9
MILES MEMORIAL HOSP DAMARISCOTTA ME 04543	4	25	2-76	1	100	1-97	9	0	1-50	8	0	0-92	38	5	1-19	20	0	0-30	4	0	0-100	48	8	2-17	20	10	0-35
MILLINOCKET REGIONAL HOSP MILLINOCKET ME 04462	3	67	2-82	2	0	1-89	2	50	0-91	.	.		34	3	1-20	6	0	0-78	2	0	0-100	26	4	1-23	10	0	0-84
MT DESERT ISLAND HOSP BAR HARBOR ME 04609	5	40	4-73	4	75	5-79	9	33	0-51	2	0	0-100	76	3	2-14	12	0	0-75	6	0	0-100	41	5	1-17	18	0	0-34
NORTHERN CUMBERLAND MEMORI BRIDGTON ME 04009	.	.		4	25	4-78	11	9	1-44	1	0	0-100	71	6	2-14	9	22	0-51	2	0	0-100	42	10	1-17	24	4	0-26
NORTHERN MAINE MED CTR FORT KENT ME 04743	5	0	2-71	9	11	12-70	7	0	1-57	.	.		47	2	3-20	17	6	1-33	3	0	0-97	43	5	1-17	14	0	0-67
OSTEOPATHIC HOSP OF MAINE PORTLAND ME 04101	6	17	5-71	7	43	11-73	40	15	3-23	8	0	0-97	128	5	3-13	53	9	2-18	12	0	0-100	102	5	2-11	76	0	0-10
PARKVIEW MEMORIAL HOSPITAL BRUNSWICK ME 04011	1	0	0-100	3	0	3-84	10	0	1-47	.	.		37	0	1-19	7	0	1-58	8	0	0-100	17	6	1-32	55	0	0-13

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	Comment/ Reference	Overall			High Risk Diagnostic Categories: Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
PENOBSCOT BAY MED CTR ROCKLAND ME 04841	ME-31	1232	12	10-17	116	27	17-36	45	36	19-46	37	8	7-33	65	25	14-35	45	33	25-54	28	7	6-37	92	13	12-31
PENOBSCOT VALLEY HOSP LINCOLN ME 04457	ME-32 *	291	16	10-20	2	0	2-90	10	30	10-63	3	33	1-81	24	17	9-42	15	40	20-67	7	71	9-71	68	26	13-34
PINELAND CTR HOSP-ACUTE UN POWNAL ME 04069	ME-33 *	4	0	0-98	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
REDINGTON FAIRVIEW GEN HOS SKOWHEGAN ME 04976	ME-34 *	734	15	11-18	58	36	18-44	36	17	15-45	7	29	6-66	67	25	14-35	42	40	21-50	13	8	8-54	72	15	12-32
REGIONAL MEMORIAL HOSPITAL BRUNSWICK ME 04011	ME-35 *	725	11	9-17	46	35	14-41	25	16	14-49	15	13	5-46	44	23	13-38	23	48	23-62	11	18	8-58	67	21	12-32
RUMFORD COMMUNITY HOSP RUMFORD ME 04276	ME-36 *	550	13	9-17	36	44	15-45	15	20	12-57	12	25	6-52	20	20	11-49	21	43	22-63	9	11	3-55	58	24	12-35
SEBASTICOOK VALLEY HOSP PITTSFIELD ME 04967	ME-37 *	242	14	8-19	11	36	6-55	12	50	9-56	2	0	0-90	17	29	8-47	15	47	17-63	4	25	3-76	23	22	9-43
ST ANDREWS HOSPITAL BOOTHBAY HARBOR ME 04538	ME-38 *	178	15	8-20	7	57	13-76	4	50	4-77	2	0	0-91	8	25	4-59	14	29	16-64	10	40	5-56	23	4	5-37
ST JOSEPH HOSPITAL BANGOR ME 04401	ME-39	923	12	10-17	96	18	15-36	24	17	14-49	14	36	9-53	73	30	15-36	30	53	25-60	21	29	8-45	75	17	12-32
ST MARYS GEN HOSP LEWISTON ME 04240	ME-40 *	1653	9	8-15	111	23	16-35	45	13	18-46	31	13	8-37	114	25	16-33	40	43	24-55	44	18	11-38	117	15	12-28
STEPHENS MEMORIAL HOSPITAL NORWAY ME 04268	ME-41 *	706	8	8-16	38	24	14-44	25	20	15-50	13	23	6-51	34	12	13-42	19	37	20-62	5	0	1-68	67	12	13-34
THE AROOSTOOK MEDICAL CENT PRESQUE ISLE ME 04769	ME-42	817	11	8-15	54	28	15-40	24	8	14-49	24	29	8-42	33	33	11-40	41	32	22-52	12	17	3-48	59	19	13-35
VAN BUREN COMM HOSP VAN BUREN ME 04785	ME-43 *	47	11	7-29	.	.		2	50	3-91	.	.		10	10	6-56	3	33	5-86	2	0	0-91	8	13	2-55
WALDO CO GENERAL HOSP BELFAST ME 04915	ME-44 *	451	14	10-18	31	26	15-47	23	30	15-51	12	17	9-57	27	26	10-41	24	46	21-59	9	22	3-54	41	10	7-32
WATERVILLE OSTEOPATHIC HOS WATERVILLE ME 04901	ME-45 *	482	10	8-16	19	26	10-49	10	30	13-68	7	14	3-62	15	13	6-47	17	41	18-62	28	18	11-44	50	16	7-28
WEBBER HOSPITAL ASSOCIATIO BIDDEFORD ME 04005	ME-46	1369	12	10-17	90	38	16-37	63	35	19-42	33	9	7-35	67	16	15-36	85	26	28-50	25	16	6-38	102	15	11-29
WESTBROOK COMM HOSP WESTBROOK ME 04092	ME-47 *	134	11	4-16	7	29	4-63	4	0	3-76	2	0	0-91	9	44	4-55	.	.		4	0	2-75	13	38	4-47
YORK HOSP-HENRY STRATER WI YORK ME 03909	ME-48	807	11	8-16	40	15	8-34	34	38	16-47	17	29	6-45	58	22	14-37	35	37	23-55	11	36	5-53	75	12	10-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
PENOBSCOT BAY MED CTR ROCKLAND ME 04841	6	33	5-71	12	17	17-69	49	6	4-24	7	0	0-100	124	5	3-12	62	5	2-17	16	0	0-57	83	4	2-12	81	1	0-9
PENOBSCOT VALLEY HOSP LINCOLN ME 04457	2	0	3-91	1	0	1-97	2	0	0-98	.	.		33	3	1-20	10	10	1-47	3	0	0-100	41	12	1-18	7	0	0-93
PINELAND CTR HOSP-ACUTE UN POWNAL ME 04069	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
REDINGTON FAIRVIEW GEN HOS SKOWHEGAN ME 04976	16	56	10-57	13	15	14-63	20	20	2-31	5	0	0-100	88	2	1-12	21	5	1-29	9	0	0-100	55	5	1-15	33	6	0-20
REGIONAL MEMORIAL HOSPITAL BRUNSWICK ME 04011	2	0	2-90	12	50	18-71	17	6	1-33	.	.		83	8	2-14	20	0	0-31	2	0	0-100	64	3	2-15	45	0	0-18
RUMFORD COMMUNITY HOSP RUMFORD ME 04276	5	20	1-71	3	33	3-84	10	10	1-47	.	.		74	8	2-14	34	3	1-22	4	0	0-100	45	2	1-17	24	0	0-30
SEBASTICOOK VALLEY HOSP PITTSFIELD ME 04967	6	0	7-74	.	.		1	0	0-98	.	.		34	9	1-21	5	0	0-85	5	0	0-100	30	3	1-23	9	0	0-78
ST ANDREWS HOSPITAL BOOTHBAY HARBOR ME 04538	.	.		2	100	3-92	5	20	0-71	.	.		17	6	0-34	11	9	1-44	.	.		12	0	0-42	9	0	0-90
ST JOSEPH HOSPITAL BANGOR ME 04401	3	0	1-82	5	40	8-78	28	4	3-29	9	0	0-100	110	5	3-13	51	2	1-17	7	0	0-100	84	2	2-13	63	2	0-11
ST MARYS GEN HOSP LEWISTON ME 04240	5	0	3-72	20	15	16-57	39	3	4-26	57	0	0-15	195	4	4-12	58	5	2-17	18	0	0-95	163	5	3-10	97	0	1-8
STEPHENS MEMORIAL HOSPITAL NORWAY ME 04268	3	33	3-83	6	33	10-76	29	7	3-27	.	.		89	6	3-14	42	2	1-19	14	0	0-80	47	4	1-16	62	0	0-11
THE AROOSTOOK MEDICAL CENT PRESQUE ISLE ME 04769	5	20	5-75	4	25	11-87	13	23	1-40	60	0	0-27	78	5	2-13	16	13	1-35	11	0	0-99	67	7	2-14	68	0	0-11
VAN BUREN COMM HOSP VAN BUREN ME 04785	2	50	0-90	.	.		.	.		.	.		3	0	0-89	.	.		.	.		5	0	0-74	.	.	
WALDO CO GENERAL HOSP BELFAST ME 04915	7	43	8-72	5	60	8-78	13	8	1-40	7	0	0-100	71	4	1-13	13	8	0-46	4	25	0-99	17	12	1-32	25	0	0-31
WATERVILLE OSTEOPATHIC HOS WATERVILLE ME 04901	6	17	3-68	2	50	4-92	22	18	5-37	.	.		51	4	2-17	21	10	1-29	4	0	0-99	41	2	1-18	53	0	0-14
WEBBER HOSPITAL ASSOCIATIO BIDDEFORD ME 04005	10	20	6-60	8	50	11-70	43	2	2-21	1	0	0-100	166	5	3-11	38	5	3-24	13	0	0-100	129	2	2-10	79	1	0-9
WESTBROOK COMM HOSP WESTBROOK ME 04092	1	0	1-97	.	.		1	0	0-100				10	20	0-50	10	20	0-48	1	0	0-100	2	0	0-95	4	0	0-99
YORK HOSP-HENRY STRATER WI YORK ME 03909	11	27	5-56	3	0	6-87	19	5	2-33	14	0	0-89	103	5	2-12	43	2	1-19	2	0	0-100	84	2	1-11	23	0	0-43

*Written Comments Not Submitted.

Bath Memorial Hospital

1356 Washington Street
Bath, Maine 04530
207-443-5524

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

I have reviewed the mortality data for the Bath Memorial Hospital and find there is only a single comment that is necessary to make. The category of Renal Disease contains a total population of one. This "one" individual expired giving rise to a mortality rate of 100%. It may be obvious to some, although not to others, that a sample size of only one is not a statistically valid sample size on which to draw any comparison. It is purely chance that the one patient in the sample expired resulting in a conclusion that suggests an excessive mortality rate.

Not wishing, however, to hide behind this statistical oddity, it is also pertinent to note that each death which occurs in the Bath Hospital is reviewed by a committee of the Medical Staff. The purpose of this committee is to determine whether or not death was unavoidable. This case was the subject of that review and the conclusion of the committee affirmed that death was unavoidable and most importantly was not the result of an inadequacy or inappropriateness of care.

Sincerely yours,

J. Neil Bassett
Exec. Vice President/Chief Operating Officer

JNB/amg

CENTRAL MAINE MEDICAL CENTER

CM/MC

LEWISTON, MAINE 04240 — TELEPHONE 207 795-0111

An Affiliate of
Voluntary Hospitals of America, Inc.

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

In a letter of September 21, 1987, HCFA presented a preview of selected Mortality Data (planned for publication December 1987), we submit the following comments:

Representatives for Central Maine Medical Center have reviewed a significant sub-sample of the deaths listed in the data. Based on the data and information submitted by HCFA we acknowledge that the data is acceptable as presented.

Central Maine Medical Center is a tertiary referral center for the Central Maine Region with services for high risk patients, including but not limited to:

* A Cancer Treatment Center
* Acute Rehabilitation Services
* Emergency Medical Services (Tri-County)
* Neurological Services

Thank you for the opportunity to comment prior to the December release of this data.

Respectfully submitted,

Peter E. Chalke
Senior Vice President
Central Maine Medical Center
300 Main Street
Lewiston, Maine 04240

MKN/PC/pv
cc: G.P. Roy, D.D.S.
President-Medical Staff

KENNEBEC VALLEY MEDICAL CENTER
6 East Chestnut Street, Augusta, Maine 04330 • (207) 626-1000
Medicare Provider 200015

October 26, 1987

Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Sir:

Thank you for your information regarding mortality data as accumulated and compiled by the Health Care Finance Administration.

Included you will find comments made by physicians who carefully reviewed mortality data provided by you.

It is our impression that the information you have provided us with is interesting, from only, general point of view, but it does not reflect actual quality of care in our institution.

Several important factors were not considered in establishing the mortality rate. Some of them would be the age of the patient, severity of the disease and complicating factors. In many instances the data was totally inaccurate when patients with the wrong diagnosis were listed under specific diagnostic categories.

We are extremely interested in providing high quality of care to our patients and we will gladly participate and help in development of more meaningful statistical data.

Yours very truly,

J. E. Ciembroniewicz

Julius E. Ciembroniewicz, M.D.
Chief of Staff

jec/ph

KENNEBEC VALLEY MEDICAL CENTER
6 East Chestnut Street, Augusta, Maine 04330 • (207) 626-1000

Medicare Provider 200015

RE: HCFA Mortality Statistics - Sepsis.

Five cases were included in HCFA Mortality Review of Sepsis. All cases were carefully reviewed.

One case was a patient who was [redacted] who was admitted to the hospital with metastatic carcinoma, semicomatose, dehydrated and expired 24 hours following admission. Urinary tract infection was present. The cause of death was due to metastatic carcinoma.

The second case was a patient who was in his early [redacted]. The patient was hospitalized because of a Klebsiella pneumonia when he was in the hospital. The patient was discharged home totally well and expired at home from unknown causes.

In the three other reviewed cases sepsis was a complicating factor in patients with other severe surgical or medical complications.

In all reviewed cases, there was only one case where death may be attributed to sepsis as a primary diagnosis.

J. Ciembroniewicz, M.D.

jc/ph

KENNEBEC VALLEY MEDICAL CENTER
6 East Chestnut Street, Augusta, Maine 04330 • (207) 626-1000
Medicare Provider #200015

RE: HCFA Mortality Statistics - Severe Trauma.

Four cases were included by HCFA in statistical evaluation of death attributed to severe trauma.

The first case was a [redacted] who suffered from severe congestive heart failure and was admitted to the hospital because of right hip fracture. This patient expired 24 hours following admission because of complications from congestive heart failure and severe coronary artery disease.

The next patient was an [redacted] who was admitted to the hospital because of right hip fracture. The patient died suddenly because of severe myocardial infarction.

The next case was a [redacted] who was admitted to the hospital because of intertrochanteric fracture of the right hip. The patient suffered from lung carcinoma, pneumonia, severe congestive heart failure and advanced diabetes mellitus. The patient expired 72 hours following admission to the hospital because of complications related to his severe medical problems.

The last case was a [redacted] who was admitted to the hospital in profound coma with unreactive fully dilated pupils, moribund. Diagnostic studies disclosed acute subdural hematoma which was promptly evaluated but the patient never recovered.

J. Ciembroniewicz, M.D.

jc/ph

KENNEBEC VALLEY MEDICAL CENTER
6 East Chestnut Street, Augusta, Maine 04330 • (207) 626-1000

Medicare Provider #200015

RE: HCFA Mortality Statistics - Renal Disease.

Four cases in HCFA Mortality review data were attributed to renal disease.

The first case is a [redacted] who suffered from severe coronary artery disease, extreme dehydration and trauma to his face. The patient was admitted to the hospital in kidney failure in a moribund state and the family requested not to use excessive means of support because of intractable multiple medical problems complicated by renal failure.

The next case is an [redacted] patient who suffered from chronic renal failure and was admitted to the hospital dehydrated, in deep coma and never recovered.

The next case was again an [redacted] patient who suffered from severe coronary artery disease and the patient was fibrillating. The patient also suffered from severe obstructive pulmonary disease and severe diabetes. The patient developed pyelonephritis with nephrosclerosis and expired.

The last case was a [redacted] patient who suffered from multiple sclerosis with paraplegia of his extremities. This patient suffered also from iron deficiency, chronic pedal edema, chronic pyelonephritis, renal calculi and hyperalbuminemia.

J. Ciembroniewicz, M.D.

jc/ph

KENNEBEC VALLEY MEDICAL CENTER
6 East Chestnut Street, Augusta, Maine 04330 • (207) 626-1000

October 9, 1987

Julius Ciembroniewicz, M.D.
15 Middle St.
Augusta, Maine 04330

RE: HCFA Mortality Statistics

Dear Julius,

Thank you so much for the opportunity to review the HCFA Mortality Statistics.

I reviewed two categories, namely, the severe acute heart disease and severe chronic heart disease. There were 32 cases of severe acute heart disease deaths. The average age of this group was over 78 years of age. The diagnostic criteria would appear to be that they chose people who developed acute MI's, which were complicated by death. However, there were 3 cases of death due to ruptured aortic aneurysm with no evidence of any heart disease mentioned in the record. There was one case of a patient with an acute MI as the listed diagnosis. This record was extensively reviewed by the CCU committee and the Family Practice Department. The conclusion was that the patient did not have an MI; the probable cause of death was not cardiac disease, but some type of pulmonary complication. The medical record does not reflect any of the discussions which occurred after the mortality review last year, and HCFA would not have been notified of any diagnostic change. Of the other 28 cases I could find one other case where the diagnosis was in question. This was a case of an 84 year-old woman who died suddenly in the hospital after being admitted for complications from compression fractures. From review of the record, it is more likely that she died from a pulmonary embolus and not from an acute MI. The cases in question, therefore, are;

[redacted] - who died of a ruptured aortic aneurysm.

[redacted] - who died of a ruptured aortic aneurysm, complicated by renal failure and severe colitis.

[redacted] - who died of a ruptured aortic aneurysm.

[redacted] - whose medical diagnosis at the time of death was acute MI, but upon review of the record the death was more likely respiratory failure.

[redacted] - who died suddenly of unknown cause, most likely from a pulmonary embolus after hospitalization for 2 weeks with compression fracture at the age of 84.

When these patients are excluded, the average age of the patients who died in this category was over 79. As you are aware, this age group has a very high mortality rate with an acute MI. All of the other patients, which number 27 after excluding the cases mentioned above, suffered from definite myocardial infarctions which were complicated. I believe the deaths were justified after reviewing the records.

As I discussed with you, the mortality rate based on hospital admissions are not meaningful data in themselves. More meaningful data would be age-adjusted mortality statistics, especially area wide population based mortality which would be meaningful reflections of the hospitals' quality of care.

The second category of patients I reviewed was severe chronic heart disease. The total number was 19. The average age of this group was over 82. Most of the patients suffered from chronic congestive heart failure with acute exacerbations. There was one person in this category who definitely had an acute MI and may have belonged in the first category, but that doesn't particularly matter. There are a few patients who do not belong in this category.

[redacted] - was admitted with CHF and was transferred to Williams Health Care Facility improved. She had multiple myoloma which was progressive and more likely died of complications of multiple myoloma at Williams Nursing home, as opposed to CHF.

[redacted] - had a diagnosis on his discharge form and on the death certificate, of cause of death as respiratory failure. CHF was mentioned as one of the diagnoses, but in reviewing the record it is clear that respiratory failure was the major problem and CHF was a minor secondary problem. I think he was placed in the wrong category.

[redacted] - was transferred from Maine Medical Center to KVMC April 28, 1986, for comfort measures basically to die, after he suffered numerous complications from an aortic valve replacement done at MMC in March of 1986. I am not sure that he belongs on our mortality statistics. Whether he belongs under heart failure, renal failure or some other category or whether he really belongs under the MMC as opposed to our statistics are some of the questions I raise.

[redacted] - did have severe CHF, was discharged to a Bath nursing home. We have no record of his death and it is unclear why he was placed under our mortality statistics.

[redacted] - who was admitted with CHF, but really died of an acute blast crisis with mylogenosis leukemia with a white blood count of 504,000. I do not believe he truly belongs under CHF.

[redacted] - who had CHF and a cerebral vascular accident. He was transferred to the Togus Veterans Administration Hospital, improved, and it is unclear what he died of at the VA Hospital, because we have no information available on that.

So, in this final category I am concerned about the presence of six of the 19 total patients in this category. Four definitely do not belong in the category under our hospital and two probably don't belong. If you remove these patients from the category, if you take into account the average age of over 82, I certainly do not think the mortality statistics are alarming.

In reviewing the other 13 records, the cases were ones of severe CHF, which were well managed, and I believe the deaths were unavoidable. I have not reviewed any of the other categories. If you would like to please let me know, I would be happy to provide this service again since it was such an enjoyable experience.

Sincerely,

Kevin Kane

Kevin Kane, M.D.

KK/ss

KENNEBEC VALLEY MEDICAL CENTER

Medical Care Evaluation

To: J. Ciembroniewicz MD Date: October 16, 1987
Chief of Staff

From: Nancy G. Favorite
Staff Assistant Vice President Medical Affairs

Re: Review of HCFA Identified Pulmonary deaths - 1986

1. 35 pulmonary records reviewed
   27 hospital deaths
   8 $\bar{p}$ hospital deaths

2. 27 hospital deaths
   17 No Code status on admission
   10 Full Code status, 3 subsequently changed to No Code

Primary dx:	Pneumonia	20	20
	$\bar{c}$ COPD	9	
	$\bar{c}$ CHF	3	
	$\bar{c}$ Ca lung c mets	1	
	$\bar{c}$ other cardiovascular	5	
	COPD	6	6
	$\bar{c}$ CHF	2	
	$\bar{c}$ pneumonia	2	
	Cardiovascular	1	1
			27

dx confirmed by autopsy in 3 cases

3. 8 cases $\bar{p}$ hospital deaths

Disch dx:	Pneumonia	6	6
	$\bar{c}$ CHF	2	
	$\bar{c}$ COPD	1	
	$\bar{c}$ other cardiovascular	3	
	COPD	2	2
			8

4. 5 Cases referred to Anesthesia Dept Chairman

   1 case determined to be AMI c̄ progressive CHF, pneumothorax & with underlying COPD
   3 cases cause of death equivocal between pulmonary disease (COPD & Pneumonia) and cardiovascular (CHF) and sepsis (1)
   1 case of out-of-hospital death, unable to determine cause of death to be either RLL pneumonia c̄ pleural effusion or related to previous CVA (Hx MI) or new onset A Fib

5. Regarding the issue of the relatively high incidence (high predicated range) of pulmonary related deaths, Dr. Jones did not feel that this was an unexpected rate given the high incidence among the population (served by this facility) due to smoking and air pollution. He indicated the only useful comparison could be attempted if the data were compared with that of a state with similar environmental factors, such as Virginia.

cc: Dr. Jones

MERCY HOSPITAL

October 27, 1987 Provider #200008

Mr. Harvey Brook
Health Standards & Quality Board
Room 2-D-2
Meadows East Bldg.
6300 Security Blvd.
Baltimore, Md. 21207

Dear Mr. Brook:

Mercy Hospital endorses the use of valid outcome measures to reflect the appropriateness of care as practiced within our institution and at other health care facilities. The development and use of a range of outcome measures, of which mortality is but one, provides an opportunity to improve the practice of medicine, the cost effectiveness of care and quality of life for patients. We support this development. We are also in agreement with your assessment that "until we have developed additional statistical measures to deal with complex issues such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals." We hope to contribute to the validity of any future methodology HCFA may use in predicting mortality by offering the following comments and corrections.

Our review of the HCFA reported mortality data, has documented an error in the classification of a patient death identified as [redacted] (see attachment). Physician review of the patient record documents that the reason for admission was incorrectly attributed to the severe chronic heart disease category. The appropriate diagnostic category for this patient is pulmonary disease. Hospital specific mortality rates in these categories are accordingly revised to 33.3% for severe acute heart disease and 13.7% for pulmonary disease. Mercy Hospital has verified all other reported deaths.

Actual mortality rates at Mercy Hospital for each of the 16 diagnostic categories fall within the predicted ranges as calculated by the HCFA methodology. In 13 of the 16 clinical categories, mortality rates have been reported as falling on the lower side of this range, below the predicted number of deaths. In five of these clinical categories (pulmonary, ophthalmologic, gynecologic, low risk heart and urologic) actual mortality rates fell at or near the lower limit of the

predicted range. In the remaining three categories, renal, severe acute heart disease, and severe chronic heart disease, corrected mortality rates fell within normal ranges, but above the predicted mid-point.

In the clinical category of renal, prediction of the actual number of deaths is statistically biased by the small number of total cases. HCFA's methodology predicted that Mercy Hospital would experience in excess of two patients deaths in this category, specifically calculating 2.4 deaths. The number of actual patient deaths reported in this category, 3, was consistent with this prediction. Accordingly, there is no clinical significance to the differentiation between actual and predicted deaths in this category.

Reported mortality rates for severe, acute and chronic heart disease, when corrected for appropriate classification, fall within predicted ranges, approaching the upper limits. Mercy Hospital's experience in these two categories appears to mirror the relatively higher death rate experienced in these two clinical categories in the Portland area as a whole. The ratios of the Portland area rate to that of the state for severe acute heart disease and severe chronic heart disease are 1.27 and 1.21 respectively. This differential may reflect the interplay of characteristics of the Portland area delivery system including expeditious access to acute care facilities, aggressive intervention of high risk patients and high occupancy rates which permit admission of only the sickest patients. Because HCFA mortality data is based on the percentage of deaths per hospitalized beneficiaries, deaths in any geographic area in which patients with severe or chronic heart disease die without admission to the hospital, will not be captured by the HCFA methodology. Interpretation of the appropriateness of Portland area mortality rates relative to those of other areas in the state must consider the nature and effect of the delivery system, area hospital utilization patterns, and the extent to which high occupancy and stringent utilization review permit admission of only the sickest patients. The usefulness of the HCFA data for quality assurance purposes would be enhanced by the use of population based, rather than hospital based data, in addressing these sources of confounding.

All patient records for Mercy Hospital specific deaths in the category of severe chronic heart disease have been reviewed by the chief of the hospital's medical service. These records document the appropriateness of Mercy Hospital's mortality experience in these categories. Patient records identify that 14 of the 28 deaths in this category carried, at the request of the family and/or the patient, orders not to resuscitate and that death was an immediately anticipated and appropriate outcome. The age distribution of patients in this category, which ranged to

91 years of age also supports the appropriateness of this mortality experience (see attachment).

Also of concern in the development of the predicted range of mortality is the inability of the HCFA methodology to capture multiple complications and co-morbidities. In predicting mortality, the HCFA methodology adjusts for the presence of "selected co-morbidities". However, this methodology which focuses on a restricted number of complicating factors, is not sufficiently sensitive to capture severity of illness or accurately predict mortality rates which reflect appropriate outcome. Mercy Hospital's patient population is characterized by relatively high severity of illness. Co-morbid and complicating conditions within our patient populations substantially exceed those which have been captured by the HCFA methodology. Accordingly, the mortality experience, while falling within normal ranges, may be overstated.

In developing valid measures of the appropriateness of care, documentation of severity of illness must be viewed as an essential element in any data base which seeks to assess quality. It is our intent to support the direction established by HCFA and the Joint Commission on Accreditation of Health Care Organizations by expanding our patient classification system to include measures of severity of illness which are consistent with the intent of the U. S. Congress to develop meaningful performance information on hospitals providing care to Medicare beneficiaries.

Yours sincerely,

Howard R. Buckley
President

HRB:gm

Correction of Patient Classification
HOSPITAL ID NUMBER = 200008

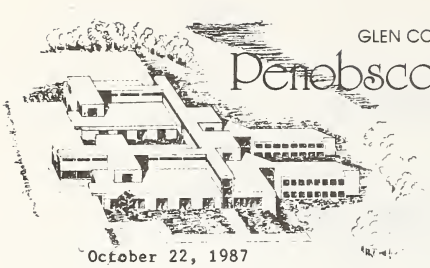
Patient ID Number (HIC)	Surname (first 6 Ltrs)	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Principal Diagnosis	Principal Procedure
[redacted]	[redacted]	PN	081	F	02/15/86	03/17/86	03/17/86	486	9904

ME 22.3

ATTACHMENT 5

Worksheet 1: Analysis of Age

Diagnostic Category	Deaths Reported by HCFA: #of deaths By Admitting DX	Deaths Reported by HCFA: Average Age	Deaths Verified by Hospital: High Age	Deaths Verified by Hospital: Low Age
CA--Cancer	30	74.4	91	66
CE--Cerebrovascular Accidents	14	82.1	98	68
GC--Gastrointestinal Catastrophes	6	80.2	89	74
GI--Gastrointestinal Disease	7	78.8	94	70
GU--Urologic Disease	1	78	-	-
GY--Gynecologic Disease	-	-	-	-
HL--Low Risk Heart Disease	2	77.5	81	74
HM--Severe Chronic Heart Disease	29	78.9	91	57
HS--Severe Acute Heart Disease	32	78.8	98	66
ME--Metabolic/Electrolyte Disturbances	3	81	85	77
OP--Orthopedic Disorders	2	76.5	79	74
PN--Pulmonary Disease	23	81	97	64
RN--Renal Disease	3	78	83	68
SE--Sepsis	3	80.3	86	74
TR--Severe Trauma	5	83	91	77
OP--Ophthalmalogic Disease				
UN--Other Diagnoses	24	78	95	48
Total--All Categories				



GLEN COVE · ROCKLAND · MAINE · 04841 · TELEPHONE · 207·594·9511

Penobscot Bay Medical Center

Medicare Provider Number - 200063

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir,

Despite the fact that this report shows that Penobscot Bay Medical Center (PBMC) is within Health Care Financing Administration's (HCFAs) "Range of Predicted Mortality Rates" we feel it is important to examine the validity of the data and the meaning of the statistics generated. The mortality information used by HCFA indicate that of a total of 1,232 Medicare patients admitted to PBMC, 144 died within 30 days of admission. The HCFA data also shows that of those who died, 116 died while still in the hospital, and that 28 died after discharge. We have no way to verify whether the number of Medicare patients identified by HCFA is correct.

A review of our records indicate that 1,961 Medicare patients were discharged in 1986. This difference in numbers of patients treated as inpatients would be expected to occur primarily due to multiple admissions of individual Medicare beneficiaries. The "actual mortality rate" as computed by HCFA is misleading. In fact, the mortality rates shown in the HCFA data includes only a unique group of patients; i.e., those whose last hospital admission occurred at PBMC and those who died within 30 days of that admission. HCFA statistics ignore the many patients who had positive outcomes from previous hospitalizations at PBMC. The mortality rate of the hospital including the outcomes of all of the hospitalizations of Medicare patients is substantially lower than is shown by the HCFA data.

Our own records also indicate that instead of the 116 Medicare patients HCFA identified who died in the hospital, 115 were dead at the time of discharge. We cannot verify HCFAs information concerning deaths occurring after discharge since events occurring after discharge are not included in the patient's medical record.

Without access to the detailed information available to HCFA and used in computing the predicted mortality rate range it is impossible to verify the accuracy of the diagnostic or other data used in making this analysis.

Patients who died after discharge may have died from the health problems for which they were last hospitalized or due to totally unrelated events such as an automobile accident. Including these patients in the hospital's mortality rates inappropriately attributes that death to a hospital and potentially inflates the mortality rate even when the death may have occurred from other and unrelated reasons. This is not a valid measure of care provided in the hospital.

The Diagnostic Categories into which patients were assigned by HCFA do not necessarily reflect the actual cause of death. For example, a patient whose last hospital admission was to repair a fractured hip may also have had terminal cancer. Such a patient would be classified as orthopedic while the more severe problem and the actual cause of death are ignored. This factor would tend to distort the mortality rates for specific Diagnostic Categories.

All factors influencing mortalities are not reflected in HCFAs analysis and prediction of mortality rates. Such things as severity of illness and family choices regarding continuation of treatment or life support are not considered at all. Meaningful analysis is also restricted by the amount and type of data available from the existing billing and Social Security processes. It is clear that given these constraints, these mortality statistics are not an accurate measure of the quality of care provided within the hospital setting.

Sincerely,

David Schwartzkopf

David Schwartzkopf
Executive Vice President

Enclosures

JR/DS:tb
AdminXII

ST.
JOSEPH
HOSPITAL

William Roper, M.D.
Administrator
Health Care Finance Administration
Department of Health and Human Services
Washington, D.C. 20201

October 26, 1987

Dear Dr. Roper:

Enclosed please find a list of the corrections that need to be added to the preexisting list that HCFA has provided for Medicare Provider numer: 20-0001.

- Missing principal procedure 9205
- Missing principal procedure 8762
- Missing principal procedure 9215
- Missing principal procedure 8875
- Missing principal procedure 9607
- Missing principal procedure 8623
- Principal diagnosis should be 585
- Missing principal procedure 8703
- Principal procedure should be 293

Sincerely,

Art Blank
Vice President of Finance

297 Center Street, Bangor, Maine 04401 207-947-8311
SPONSORED BY THE FELICIAN SISTERS

TAMC THE AROOSTOOK MEDICAL CENTER

October 19, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The Aroostook Medical Center (TAMC) offers the following comments to HCFA in response to your letter of 21 Sep 87 regarding selected mortality information on our hospital.

We believe objective measurement, analysis, and dissemination of information about quality is key to achieving improvement in the medical care delivered at our hospital. The release of appropriate data on quality can assist the public and us in reaching that goal. However, data which purports to meet that objective but in actuality has serious flaws in its reliability and validity can only hurt the objectives of TAMC and of HCFA. The model used does not demonstrate a strong correlation between mortality and the quality of care.

Specifically, the model does not account for the intensity or severity of patient illness. Therefore, the absence of a severity variable and the resulting mortality calculations will render erroneous or misleading data for many hospitals, particularly those such as TAMC which is a 117 bed hospital in northern Maine. Second, we also feel the methodology may not be reliable because of the relatively small number of Medicare patients (817) we served and therefore, the few deaths (92) that we experienced. We suggest HCFA institute a minimum threshold of admissions for each mortality rate category and if that threshold is not reached, do not publish that category's mortality rate. Third, deaths not related to admitting diagnoses should be removed from the data if you wish to correlate mortality data to quality of care.

Since HCFA also intends to have the PRO's analyze the information in conjunction with its ongoing activities, we feel their use of the mortality data be clearly defined. Appropriate mortality data is merely one of many tools needed by the PRO to help assess overall quality.

We strongly recommend, therefore, given your reservations as outlined on page 3 of your letter which states "...we cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital..." plus the shortcomings in the methodology, that you do not publish the present data. We further recommend HCFA work with other researchers which are already involved in numerous projects to improve the measurement of quality. We would be glad to assist HCFA in refining its methodology prior to its publication.

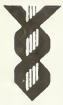
We appreciate the opportunity to present our view on your proposed release of hospital mortality information and ask you to carefully consider our suggestions.

Cordially,

David A. Peterson
Executive Director

GP/pcc:12574

pc: Richard Wilson, M.D., Medical Director
Thomas Gross, M.D., Chairperson, QA Committee
Ronald Rohe, M.D.
James Castle



SOUTHERN MAINE MEDICAL CENTER

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: Hospital #200019

Dear Sir/Madam:

The overall 1986 Medicare Mortality Rate for Southern Maine Medical Center was 12% compared to the Health Care Financing Administrtion range of predicted mortality rates from 10% to 17%. Therefore, the 1986 Medicare Mortality Rate of Southern Maine Medical Center fell below the Health Care Financing Administration predicted midpoint of 13.5%. The actual number of Medicare deaths, 158, was 27 less deaths than predicted, a 15% difference.

The Maine Health Information Center, based in Augusta, Maine, provided Southern Maine Medical Center with population-based death rates for the Biddeford Primary Care Analysis Area which Southern Maine Medical Center serves. The death rates for both Medicare and non-Medicare patients in the area were equal to predicted state death rates. The Biddeford area had 185 deaths among Medicare patients during the period while 184 deaths were predicted. There were 50 deaths among non-Medicare patients while 52 deaths were predicted.

Mortality rates, by themselves, do not measure quality. Actual mortality rates can be higher or lower than predicted because the patients treated by the hospital differ from the patients treated in the "average" hospital, or because the care provided differs from the care provided in the "average" hospital or simply because of chance. Comparisons of actual and predicted mortality rates can only suggest that the hospital and its medical staff review an area to determine if a quality problem does exist, if the patients treated by the hospital are simply unusually complex, or if patients have other characteristics not recognized by the Health Care Financing Administration model that would lead to an above average mortality rate.

The quality of care that is delivered by Southern Maine Medical Center is of high quality and is of the utmost interest and concern to the hospital's Board of Directors, Medical Staff, and management. Any indication of potential quality problems, including a mortality rate that is higher or lower than predicted, leads to a prompt investigation to determine if a problem, in fact, exists. The Quality Assurance Committee of Southern Maine Medical Center will thoroughly examine the clinical categories in the data provided by the Health Care Financing Administration in which the Medicare Mortality Rates are significantly higher or lower than predicted. If quality problems are identified, corrective action will be taken.

Sincerely,

Philip K. Reiman
Executive Director

mld/PKR

cc: Thomas Wells, President
Board of Directors

James Georgitis, M.D.
President, Medical Staff

Leslie Tripp, M.D.
Chairman, Quality Assurance Committee

York Hospital 15 HOSPITAL DRIVE • YORK, MAINE 03909-1099 • TEL. 363-4321

DATA VERIFICATION

The data used by HCFA indicate that a total of 89 Medicare patients admitted to York Hospital died within 30 days of admission. Of these, 69 died while still a patient of the hospital, while 20 died after discharge. Our own records indicate that 1328 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at York Hospital is correct. Our own records also indicate that of the 70 Medicare patients who died within 30 days of admission while still an inpatient, 19 were still alive at the time of discharge. It is impossible to determine the percentage of the 19 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

INTERPRETIVE REMARKS

In 0 of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. After correcting the errors in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate falls to 0.

UNIQUE SERVICES RESULTING IN HIGHER THAN AVERAGE MORTALITY

None

RESULTS OF PRELIMINARY MEDICARE RECORD REVIEW

(See attached)

YORK HOSPITAL
YORK, MAINE

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	4	2	6	3
CE -- Cerebrovascular Accidents	13		14	
GC -- Gastrointestinal Catastrophes	4	1	4	1
GI -- Gastrointestinal Disease	5		3	
GU -- Urologic Disease	1			
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease	1	1	1	1
HM -- Severe Chronic Heart Disease	7	6	11	6
HS -- Severe Acute Heart Disease	11	2	13	2
ME -- Metabolic/Electrolyte Disturbances	4		2	
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease	8	1	7	1
RN -- Renal Disease	3		2	
SE -- Sepsis				
TR -- Severe Trauma		1		1
OP -- Ophthalmalogic Disease				
UN -- Other Diagnoses	8	6	7	4
Total -- All Categories	69	20	70	19

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

Maryland

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	Comment/ Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease								
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent					
AMI DOCTORS HOSP PRINCE GE LANHAM MD 20801	MD-7 *	1586	11	9-16	120	24	17-36	82	23	19-39	30	13	7-37	99	26	15-32	31	42	23-57	50	30	12-38	101	15	12-29					
ANNE ARUNDEL GEN HOSP ANNAPOLIS MD 21401	MD-8	2524	14	9-16	274	31	20-35	107	27	20-39	69	13	8-29	115	23	16-32	90	40	26-48	50	24	8-33	206	19	13-26					
BALTIMORE COUNTY GENERAL H RANDALLSTOWN MD 21133	MD-9 *	2732	15	10-16	196	20	17-33	116	31	19-36	60	22	8-30	154	25	15-29	154	39	31-49	102	27	8-28	264	27	15-28					
BON SECOURS HOSP BALTIMORE MD 21223	MD-10	1576	12	10-17	119	34	21-40	77	16	18-38	27	26	7-38	118	15	14-30	37	22	24-56	49	22	10-36	155	16	13-28					
CALVERT MEMORIAL HOSP PRINCE FREDERICK MD 20678	MD-11	833	12	9-16	37	27	13-43	54	30	19-44	25	12	6-38	36	22	13-41	34	44	25-58	23	22	8-43	73	18	9-28					
CARROLL COUNTY GEN HOSP WESTMINSTER MD 21157	MD-12	1494	13	10-16	93	29	14-35	78	24	18-39	44	11	7-31	83	24	15-33	119	28	27-47	28	21	5-36	123	22	12-28					
CHILDRENS HOSP INC BALTIMORE MD 21211	MD-13 *	285	0	0-10	1	0	0-97	.	.		.	.		.	.								3	0	1-81					
CHURCH HOSP CORP BALTIMORE MD 21231	MD-14	2063	11	10-16	174	30	22-39	77	25	17-38	26	19	10-44	138	18	14-29	62	32	25-50	42	21	10-37	164	15	13-27					
DORCHESTER GENERAL HOSP CAMBRIDGE MD 21613	MD-15	809	13	10-17	64	31	15-39	33	36	15-46	12	33	4-50	62	21	13-34	29	24	23-58	22	14	5-39	81	20	12-31					
EDWARD W MCCREADY MEMORIAL CRISFIELD MD 21817	MD-16 *	290	10	9-19	8	25	7-64	12	25	9-57	7	0	1-58	18	17	9-47	16	38	23-69	4	25	3-77	53	6	8-29					
EUGENE LELAND MEMORIAL HOS RIVERDALE MD 20737	MD-17	730	12	8-16	44	20	9-36	27	26	14-48	24	4	6-39	45	27	13-38	27	52	24-60	10	10	4-54	61	23	12-33					
FALLSTON GENERAL HOSP FALLSTON MD 21047	MD-18	1473	10	9-16	81	25	18-41	53	23	18-44	18	28	6-44	76	17	14-34	74	24	28-52	24	29	10-45	106	14	13-30					
FRANCIS S KEY MED CTR MASO BALTIMORE MD 21224	MD-19 *	31	29	5-30	2	100	0-93	9	11	7-61	1	100	0-99	.	.		1	0	1-97	.	.		3	33	1-81					
FRANCIS SCOTT KEY MED CTR BALTIMORE MD 21224	MD-20	1784	17	10-17	102	30	20-41	69	30	16-38	33	24	11-41	123	20	14-30	114	41	29-48	39	33	10-39	166	26	15-30					
FRANKLIN SQUARE HOSP BALTIMORE MD 21237	MD-21 *	3431	13	10-16	276	31	22-38	115	21	20-37	86	16	9-28	177	21	17-30	148	34	29-46	113	19	11-31	307	24	14-26					
FREDERICK MEMORIAL HOSP FREDERICK MD 21701	MD-22	1999	14	11-18	246	32	20-36	128	24	21-38	34	26	8-36	118	19	16-32	80	49	28-51	30	23	7-38	211	19	12-25					
FROSTBURG COMM HOSP FROSTBURG MD 21532	MD-23 *	371	12	10-20	6	33	5-69	14	36	9-53	4	50	10-85	36	19	13-41	16	38	17-62	9	22	3-54	82	13	13-33					
GARRETT COUNTY MEMORIAL HO OAKLAND MD 21550	MD-24	779	14	10-17	37	41	16-46	11	27	9-59	8	25	3-58	55	36	15-39	27	22	24-61	24	13	6-39	107	29	15-33					
GOOD SAMARITAN HOSP BALTIMORE MD 21239	MD-25	1864	9	7-14	139	26	17-36	33	30	17-48	30	23	8-38	78	18	14-34	58	34	27-53	37	11	7-34	106	21	13-30					
GREATER BALTIMORE MEDICAL BALTIMORE MD 21204	MD-26	2879	9	9-15	346	19	17-32	91	19	21-41	62	10	9-31	109	23	15-31	76	41	31-54	50	24	10-36	212	14	14-28					
GREATER LAUREL-BELTSVILLE LAUREL MD 20810	MD-27 *	836	12	9-16	46	20	14-41	41	39	17-45	15	40	8-51	44	14	10-35	37	27	24-56	22	18	7-43	66	27	11-32					
HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE MD 21078	MD-28	1318	12	8-15	52	25	15-41	44	34	15-42	30	17	5-34	96	20	14-32	50	36	23-50	66	24	9-32	103	18	10-27					
HOLY CROSS HOSPITAL SILVER SPRING MD 20910	MD-29 *	3148	13	9-15	276	15	15-30	117	23	19-37	100	16	9-27	170	18	17-31	117	43	31-50	93	27	10-31	294	25	15-27					
HOWARD COUNTY GENERAL HOSP COLUMBIA MD 21044	MD-30 *	1243	12	9-16	64	27	16-40	53	13	16-40	33	9	7-35	66	21	14-35	55	35	26-53	24	17	6-39	138	22	13-29					
JAMES LAWRENCE KERNAN HOSP BALTIMORE MD 21207	MD-31 *	191	2	1-10	.	.		.	.		.	.		.	.		.	.		.	.		.	.						
JOHN F KENNEDY INSTITUTE BALTIMORE MD 21205	MD-32 *	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics					
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent			
AMI DOCTORS HOSP PRINCE GE LANHAM MD 20801	14	36	10-59	21	33	17-58	34	12	3-26	12	0	0-69	164	3	2-10	72	3	1-15	16	0	0-93	142	6	2-10	134	1	0-6			
ANNE ARUNDEL GEN HOSP ANNAPOLIS MD 21401	28	14	6-43	12	33	12-62	75	12	3-18	31	0	0-44	210	6	2-9	138	4	2-12	24	0	0-98	189	6	2-8	179	2	0-5			
BALTIMORE COUNTY GENERAL H RANDALLSTOWN MD 21133	21	29	9-51	38	39	22-55	67	9	3-18	16	0	0-70	259	4	3-9	154	4	3-13	8	0	0-100	227	4	2-8	167	1	0-6			
BDN SECOURS HOSP BALTIMORE MD 21223	22	41	7-48	4	50	8-83	13	0	2-41	4	25	0-100	163	7	3-11	82	9	2-15	14	0	0-99	144	4	2-9	47	0	0-15			
CALVERT MEMORIAL HOSP PRINCE FREDERICK MD 20678	9	44	6-63	7	43	11-73	10	0	0-48	1	0	0-100	93	2	2-12	39	8	2-21	9	0	0-96	89	4	1-11	43	0	0-16			
CARROLL COUNTY GEN HOSP WESTMINSTER MD 21157	11	36	5-56	22	27	14-54	51	2	3-20	5	0	0-100	137	5	2-10	80	4	1-13	19	0	0-84	181	4	2-8	39	0	0-20			
CHILDRENS HOSP INC BALTIMORE MD 21211	.			.	.		2	0	0-96	5	0	0-100	.			.			.	.		10	0	0-62	182	0	0-5			
CHURCH HOSP CORP BALTIMORE MD 21231	13	15	9-60	32	31	21-56	25	4	4-33	16	0	0-88	259	5	3-10	79	9	2-16	11	0	0-83	216	6	2-9	115	2	0-7			
DORCHESTER GENERAL HOSP CAMBRIDGE MD 21613	8	25	6-65	6	33	9-75	26	8	2-28	3	0	0-100	73	4	2-14	40	3	1-19	5	0	0-100	72	1	2-13	38	0	0-18			
EDWARD W MCCREADY MEMORIAL CRISFIELD MD 21817	5	0	5-75	4	0	7-82	2	50	0-95	.	.		37	0	1-19	11	0	0-45	2	0	0-100	29	3	1-22	3	0	0-99			
EUGENE LELAND MEMORIAL HOS RIVERDALE MD 20737	7	29	2-63	16	25	15-61	22	18	2-29	2	0	0-100	62	2	1-14	42	5	1-19	1	0	0-100	57	9	2-16	35	0	0-20			
FALLSTON GENERAL HOSP FALLSTON MD 21047	10	20	8-64	14	21	15-64	27	22	2-28	18	6	0-73	140	2	3-12	72	6	2-16	6	0	0-100	191	6	3-9	92	0	0-9			
FRANCIS S KEY MED CTR MASO BALTIMORE MD 21224	.			.	.		4	0	0-86	.			.	.		.	.		.			.	.		1	0	0-100			
FRANCIS SCOTT KEY MED CTR BALTIMORE MD 21224	32	9	3-38	23	70	19-59	50	22	3-21	4	0	0-100	102	6	3-14	94	12	2-14	1	0	0-100	164	8	3-10	79	4	0-9			
FRANKLIN SQUARE HOSP BALTIMORE MD 21237	28	46	14-53	32	44	21-56	68	4	4-20	22	5	0-58	374	6	3-9	160	4	2-12	25	0	0-67	292	5	2-8	188	2	0-5			
FREDERICK MEMORIAL HOSP FREDERICK MD 21701	13	15	7-56	12	42	15-67	69	7	4-20	13	0	0-83	203	4	2-9	96	1	1-13	21	0	0-83	191	3	2-9	115	2	0-7			
FROSTBURG COMM HOSP FROSTBURG MD 21532	2	0	2-90	4	100	11-87	5	20	1-67	.	.		36	0	1-20	4	0	0-74	.			53	0	1-15	5	20	0-91			
GARRETT COUNTY MEMORIAL HD OAKLAND MD 21550	7	43	10-74	7	86	15-78	23	0	2-30	1	0	0-100	99	3	2-12	47	2	2-20	7	0	0-100	71	7	2-13	19	0	0-34			
GOOD SAMARITAN HOSP BALTIMORE MD 21239	18	17	5-47	11	36	15-68	28	14	3-28	4	0	0-100	156	6	2-10	83	2	1-14	11	0	0-98	113	3	2-10	303	1	0-4			
GREATER BALTIMORE MEDICAL BALTIMORE MD 21204	17	24	8-53	16	38	19-65	75	9	5-20	223	0	0-3	253	4	3-10	92	5	1-13	61	2	0-18	198	1	2-9	97	0	0-8			
GREATER LAUREL-BELTSVILLE LAUREL MD 20810	10	0	7-62	6	33	6-71	26	12	2-28	2	0	0-99	70	10	2-15	35	11	1-22	6	0	0-100	77	4	2-13	33	6	0-25			
HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE MD 21078	13	23	5-54	7	29	10-72	24	8	2-29	2	0	0-100	119	8	2-12	43	7	1-19	8	0	0-100	186	4	2-8	60	3	0-12			
HOLY CROSS HOSPITAL SILVER SPRING MD 20910	29	17	5-41	30	37	22-58	123	5	4-15	14	0	0-86	324	6	2-8	210	5	1-10	41	0	0-67	199	10	2-9	175	1	0-6			
HOWARD COUNTY GENERAL HOSP COLUMBIA MD 21044	13	8	6-55	21	43	18-59	34	12	2-23	9	0	0-100	106	2	2-12	67	13	2-17	4	0	0-100	118	5	2-10	47	0	0-15			
JAMES LAWRENCE KERNAN HOSP BALTIMORE MD 21207				.	.		11	9	2-47	.	.		.	.		.			.			.			144	1	0-6			
JOHN F KENNEDY INSTITUTE BALTIMORE MD 21205	.	.		.	.		.			.	.		.	.		.			.			.			.	.				

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease								
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent					
JOHN HOPKINS HOSP BALTIMORE MO 21205	MO-33 *	150	33	22-38	86	34	24-46	.	.	.	2	100	7-95	2	0	1-89	.	.	.	3	33	9-90	8	50	14-74					
JOHNS HOPKINS HOSP BALTIMORE MD 21205	MD-34	4493	7	6-12	457	12	17-30	93	13	18-37	81	10	9-29	131	21	17-32	116	34	28-47	44	11	7-33	200	18	12-26					
KENT QUEEN ANNES HOSP CHESTERTOWN MD 21620	MD-35	734	12	9-16	56	32	16-42	28	36	15-48	9	0	2-52	42	21	11-36	24	38	19-56	8	25	5-61	77	6	10-29					
LIBERTY MEDICAL CNTR BALTIMORE MD 21216	MD-36	798	14	10-17	31	35	19-53	40	13	16-45	29	21	6-35	57	23	14-36	12	42	14-64	56	29	11-36	54	31	13-36					
MARYLAND GEN HOSP BALTIMORE MD 21201	MD-37	1521	13	8-15	107	26	16-36	51	27	16-41	27	26	6-37	75	13	14-33	50	40	24-51	53	21	9-34	118	20	11-27					
MEM HOSP AND MED CTR CUMBE CUMBERLAND MD 21502	MD-38	2225	12	9-16	120	34	18-37	91	20	18-38	25	32	8-41	146	21	17-32	63	46	26-51	44	11	7-33	236	22	15-28					
MEMORIAL HOSP AT EASTON EASTON MD 21601	MD-39	2064	13	10-16	178	28	16-33	93	23	18-37	55	20	11-34	133	24	16-31	96	30	29-50	32	28	9-39	151	20	13-28					
MERCY HOSP INC BALTIMORE MD 21202	MD-40 *	2030	11	8-15	215	31	20-37	57	25	15-39	42	19	6-31	83	22	14-33	72	25	25-49	30	17	7-38	155	18	13-28					
MONTGOMERY GENERAL HOSPITA OLNEY MD 20832	MD-41 *	1236	11	7-14	76	20	15-37	39	26	15-43	31	13	5-33	54	28	13-35	53	53	28-55	18	6	6-45	74	16	11-31					
NEW HOSPITAL INC LUTHERAN BALTIMORE MD 21216	MD-42 *	647	19	10-18	35	37	13-44	30	27	13-44	27	30	8-40	45	27	11-35	14	7	16-63	23	22	10-46	60	27	11-33					
NORTH ARUNDEL HOSPITAL GLEN BURNIE MD 21061	MD-43 *	2651	11	8-15	172	30	17-35	83	27	18-38	57	12	7-29	188	21	16-29	99	33	27-47	66	21	9-32	276	17	12-24					
NORTH CHARLES GENERAL HOSP BALTIMORE MD 21218	MD-44	1288	10	8-14	56	27	18-44	44	32	17-44	17	12	9-50	78	27	14-34	18	44	21-64	46	15	6-31	94	23	14-32					
PARKWOOD HOSPITAL CLINTON MD 20735	MD-45	38	11	3-25	.	.	.	1	100	1-97	.	.	.	3	33	2-82	.	.	.	.	.	.	5	20	1-67					
PENINSULA GENL HOSP SALISBURY MD 21801	MD-46 *	4027	11	9-15	335	23	19-33	147	27	20-36	77	21	11-32	257	19	16-28	151	38	28-46	114	21	11-31	323	16	13-24					
PHYSICIANS MEMORIAL HOSPIT LA PLATA MD 20646	MD-47	859	14	10-17	34	26	16-47	47	28	15-41	12	42	9-58	72	21	14-34	39	31	23-53	34	21	10-40	90	26	10-28					
PRINCE GEORGES GENL HOSP CHEVERLY MD 20785	MD-48 *	1676	12	8-15	91	20	17-38	72	25	18-39	47	19	9-34	96	17	14-32	59	41	25-51	40	20	9-36	134	24	11-27					
PROVIDENT HOSP BALTIMORE MD 21215	MD-49 *	315	15	7-16	16	19	6-46	15	33	8-51	1	0	0-99	33	12	8-36	10	40	15-70	8	25	6-63	28	36	8-38					
SACRED HEART HOSPITAL CUMBERLAND MD 21502	MD-50	2058	11	10-16	167	38	22-40	71	13	16-37	27	15	8-39	123	25	16-32	75	33	27-51	37	22	17-49	178	19	15-29					
SHADY GROVE ADVENTIST HOSP ROCKVILLE MD 20850	MD-51 *	1409	15	9-16	99	25	15-35	61	23	18-41	42	24	8-34	89	29	15-33	57	37	25-51	22	5	6-42	114	26	13-30					
SINAI HOSPITAL BALTIMORE MD 21215	MD-52	3206	12	10-16	290	21	19-34	90	23	20-40	69	19	10-31	155	12	17-31	185	33	32-49	51	20	10-36	202	23	15-29					
SOUTH BALTIMORE GEN HOSP BALTIMORE MD 21230	MD-53 *	2342	12	9-16	209	27	21-38	74	20	17-38	61	11	9-31	114	15	15-31	83	24	25-47	70	16	9-31	214	21	13-26					
SOUTHERN MARYLAND HOSPITAL CLINTON MD 20735	MD-54	2013	15	9-16	173	31	20-37	71	30	18-40	34	18	7-35	123	40	17-33	50	46	24-52	78	27	10-32	150	21	11-26					
ST AGNES HOSPITAL BALTIMORE MD 21229	MD-55	3745	13	10-16	396	20	16-30	171	29	20-35	130	12	9-26	221	19	15-27	219	37	30-46	76	16	9-31	264	20	13-26					
ST JOSEPH HOSPITAL BALTIMORE MD 21204	MD-56	4241	12	9-15	347	22	17-31	146	27	20-36	82	20	11-32	233	26	17-30	189	31	30-46	111	19	11-30	220	29	14-27					
ST MARYS HOSP LEONARDTOWN MD 20650	MD-57 *	867	16	11-18	64	45	17-41	36	36	17-47	26	23	10-43	43	28	15-41	37	27	23-54	27	19	6-38	117	21	12-29					
SUBURBAN HOSPITAL ASSOCIAT BETHESDA MD 20014	MD-58	2298	11	9-16	172	15	14-30	102	18	19-38	71	20	10-30	116	29	16-33	92	34	31-52	40	10	10-38	169	21	16-30					

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
JOHN HOPKINS HOSP BALTIMORE MD 21205	.			4	25	10-86	.			.	.		7	29	3-60	1	0	0-100	.	.		3	33	0-81	.	.	
JOHNS HOPKINS HOSP BALTIMORE MD 21205	44	11	4-36	25	56	18-57	32	9	2-25	509	0	0-2	232	7	3-10	168	3	2-11	25	0	0-27	572	6	3-7	232	0	0-5
KENT QUEEN ANNES HOSP CHESTERTOWN MD 21620	6	0	4-69	13	38	18-68	13	23	1-40	5	0	0-100	86	5	1-12	37	5	1-20	6	17	0-99	79	5	2-13	21	0	0-42
LIBERTY MEDICAL CNTR BALTIMORE MD 21216	4	25	6-82	11	36	17-71	4	25	0-79	2	0	0-100	66	6	2-16	65	14	4-19	1	0	0-99	86	6	2-13	9	0	0-73
MARYLAND GEN HOSP BALTIMORE MD 21201	23	48	10-51	20	55	19-61	26	12	2-27	44	0	0-44	118	8	2-11	92	11	2-14	9	0	0-93	140	6	2-9	57	2	0-17
MEM HOSP AND MED CTR CUMBE CUMBERLAND MD 21502	20	50	13-56	34	38	23-57	57	12	4-21	10	0	0-99	195	6	3-11	91	9	2-15	15	0	0-56	258	3	3-8	111	2	0-7
MEMORIAL HOSP AT EASTON EASTON MD 21601	13	15	12-63	13	69	15-65	58	10	3-19	9	0	0-99	178	4	3-10	102	9	2-14	21	0	0-66	180	3	2-9	138	3	0-6
MERCY HOSP INC BALTIMORE MD 21202	22	14	10-51	9	33	13-71	36	8	2-23	67	0	0-16	174	3	2-9	130	8	2-13	19	0	0-86	206	3	2-8	130	2	0-7
MONTGOMERY GENERAL HOSPITA OLNEY MD 20832	9	33	6-63	9	22	14-72	48	10	2-19	11	0	0-97	97	7	2-12	67	3	1-15	14	0	0-100	118	3	2-10	70	3	0-10
NEW HOSPITAL INC LUTHERAN BALTIMORE MD 21216	12	42	11-63	17	41	20-65	8	0	0-55	.	.		62	6	2-16	63	16	4-20	1	0	0-100	55	5	1-13	9	0	0-89
NORTH ARUNDEL HOSPITAL GLEN BURNIE MD 21061	23	9	6-45	33	36	20-54	46	7	2-20	10	0	0-100	269	4	2-8	116	8	3-14	16	0	0-91	316	3	2-7	124	0	0-7
NORTH CHARLES GENERAL HOSP BALTIMORE MD 21218	4	50	4-79	17	24	18-63	13	15	1-40	55	0	0-18	87	6	2-13	62	10	2-16	8	0	0-100	196	2	2-8	39	3	0-17
PARKWOOD HOSPITAL CLINTON MD 20735	2	0	1-90	1	0	0-97	1	0	0-100	.	.		5	0	0-77	2	0	0-97	.	.		4	0	0-79	3	0	0-100
PENINSULA GENL HOSP SALISBURY MD 21801	28	36	11-49	23	35	16-56	97	10	4-18	59	0	0-16	376	4	3-9	116	3	2-13	25	0	0-94	524	4	3-7	187	2	0-5
PHYSICIANS MEMORIAL HOSPIT LA PLATA MD 20646	14	14	7-55	13	31	15-64	18	11	3-36	2	0	0-100	104	7	2-11	39	8	1-20	10	20	0-93	69	1	1-13	36	0	0-21
PRINCE GEORGES GENL HOSP CHEVERLY MD 20785	25	0	6-44	16	50	12-56	43	7	2-21	3	0	0-100	148	2	2-10	74	14	3-17	9	0	0-99	155	5	2-10	80	4	0-9
PROVIDENT HOSP BALTIMORE MD 21215	1	0	0-97	5	60	8-78	3	0	0-94	.	.		13	8	0-40	17	6	0-35	.	.		32	13	1-20	9	0	0-94
SACRED HEART HOSPITAL CUMBERLAND MD 21502	11	27	7-60	11	18	17-71	57	18	3-20	5	0	0-100	185	4	3-10	78	6	2-16	23	0	0-46	209	2	3-9	113	0	0-7
SHADY GROVE ADVENTIST HOSP ROCKVILLE MD 20850	14	14	9-57	14	64	17-65	66	5	3-19	8	0	0-100	132	9	3-12	62	5	1-16	10	0	0-93	120	8	2-10	98	0	0-8
SINAI HOSPITAL BALTIMORE MD 21215	19	26	8-51	52	62	27-56	85	4	3-16	128	0	0-7	272	4	2-9	131	3	1-12	35	0	0-63	322	6	3-8	156	1	0-6
SOUTH BALTIMORE GEN HOSP BALTIMORE MD 21230	22	23	11-52	56	43	22-50	42	0	4-24	21	0	0-79	208	7	2-9	136	3	2-12	19	0	0-93	241	4	2-8	119	0	0-7
SOUTHERN MARYLAND HOSPITAL CLINTON MD 20735	19	16	7-49	21	43	16-57	39	18	2-22	12	0	0-96	201	5	3-10	110	7	2-13	9	0	0-100	162	4	2-10	139	2	0-6
ST AGNES HOSPITAL BALTIMORE MD 21229	30	27	11-49	30	47	20-56	99	8	4-17	30	3	0-53	380	6	3-9	176	7	3-13	51	0	0-49	367	5	2-7	187	1	0-5
ST JOSEPH HOSPITAL BALTIMORE MD 21204	22	36	8-49	62	29	21-48	133	6	4-15	29	0	0-57	456	4	2-7	179	9	2-11	53	0	0-45	583	5	3-7	225	0	0-5
ST MARYS HOSP LEONARDTOWN MD 20650	13	46	7-56	7	57	10-73	21	14	2-31	5	0	0-100	101	4	2-12	36	0	1-21	3	0	0-100	98	4	2-12	27	4	0-23
SUBURBAN HOSPITAL ASSOCIAT BETHESDA MD 20014	21	38	11-54	38	34	20-52	87	5	3-16	16	0	0-86	205	9	3-11	94	2	2-14	10	0	0-96	175	9	2-9	210	1	0-5

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HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
UNION HOSP CECIL COUNTY ELKTON MD 21921	MD-59	1141	11	8-15	76	24	13-34	36	25	16-45	21	14	2-34	60	30	13-34	58	38	24-49	32	16	4-32	149	23	12-27
UNION MEMORIAL HOSP BALTIMORE MD 21218	MD-60	3508	10	9-15	333	21	15-30	145	21	20-36	63	13	9-30	198	20	16-29	170	30	32-49	72	18	8-30	214	21	14-28
UNIVERSITY OF MARYLAND HOS BALTIMORE MD 21201	MD-61	2293	14	8-15	239	25	20-36	71	31	17-39	47	17	9-34	66	17	13-34	47	40	23-51	50	24	11-37	94	17	11-28
WASHINGTON ADVENTIST HOSP TAKOMA PARK MD 20012	MD-62	1896	11	9-16	127	29	21-41	49	16	18-44	49	8	5-28	80	13	14-33	77	31	26-49	36	11	7-35	144	22	14-29
WASHINGTON COUNTY HOSP HAGERSTOWN MD 21740	MD-63	2907	12	10-16	255	21	17-33	115	24	19-37	91	9	8-26	164	20	16-30	166	38	30-47	65	12	8-30	222	21	13-26
WYMAN PARK HEALTH SYSTEM BALTIMORE MD 21211	MD-64 *	114	11	2-14	4	25	3-77	.	.		1	0	0-99	1	0	0-98	2	100	3-90	5	0	1-69	10	20	2-49

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
UNION HOSP CECIL COUNTY ELKTON MD 21921	8	13	2-60	9	11	9-65	24	4	1-27	.	.	.	120	2	1-10	47	4	1-18	5	0	0-100	136	3	2-9	50	0	0-22
UNION MEMORIAL HOSP BALTIMORE MD 21218	28	11	5-41	25	24	16-54	115	8	4-16	2	0	0-100	305	3	3-9	178	4	2-12	17	0	0-77	283	4	3-8	224	2	0-5
UNIVERSITY OF MARYLAND HOS BALTIMORE MD 21201	28	25	7-44	16	38	19-66	60	27	3-18	26	0	0-54	104	14	3-14	75	11	2-15	8	0	0-94	295	11	3-9	87	14	0-9
WASHINGTON ADVENTIST HOSP TAKOMA PARK MD 20012	17	6	5-49	25	40	21-60	27	7	2-27	10	0	0-96	125	2	2-10	50	4	1-17	11	0	0-99	398	4	2-7	67	0	0-11
WASHINGTON COUNTY HOSP HAGERSTOWN MD 21740	33	36	8-44	21	33	18-60	91	5	5-19	14	0	0-80	275	5	3-10	139	4	2-12	18	0	0-88	229	4	3-9	168	2	0-6
WYMAN PARK HEALTH SYSTEM BALTIMORE MD 21211	.	.	.	1	0	0-97	.	.	.	3	0	0-100	3	33	0-92	9	0	0-77	1	0	0-100	18	11	0-31	3	0	0-100

*Written Comments Not Submitted.

THE ANNE ARUNDEL GENERAL HOSPITAL

October 28, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Hubert H. Humphrey Building - 314 G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper,

Following are our comments on the HCFA mortality data recently received.

The data used by HCFA indicate that a total of 333 Medicare patients admitted to Anne Arundel General Hospital (AAGH) died within 30 days of admission. Of these, 273 died while still a patient of the hospital, while 60 died after discharge.

Our own records indicate that 3,928 Medicare admissions occurred in 1986. The HCFA data indicate a total of 2,524 Medicare beneficiaries were treated as in-patients in 1986. This latter figure does not count multiple admissions of those beneficiaries. We have no way of verifying the number of Medicare beneficiaries.

The hospital's data system does not allow a ready way to verify the HCFA case data for the 273 in-house deaths. We did, however, perform the following general verifications:

1) The HCFA case list was checked against the hospital's master patient index. All patients on the HCFA list were found to have been AAGH patients. All had in-patient hospitalizations in 1986. None had return visits to AAGH subsequent to the date of death listed by HCFA. We did find that one patient was listed twice (corrected listing is attached).

2) The hospital's case mix data base was consulted. Number of deaths per HCFA diagnosis category were matched against HCFA figures (extrapolated). While we did note some variation in comparison numbers per category, the aggragate number of Medicare deaths were quite close, being within 2.5% in our sample.

FRANKLIN & CATHEDRAL STREETS • ANNAPOLIS • MARYLAND 21401 • (301) 267-1000 • C.A. BRUNETTO • ADMINISTRATOR

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

3) Because of the sample size and the relatively short time frame for response to HCFA, individual medical records were not pulled from file and examined to verify the HCFA figures.

It was not possible to verify the number of Medicare patients dying after discharge, as information concerning death after discharge is not included in the patient's medical record or the hospital's master patient index.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, we do not feel it is possible to verify the accuracy of the diagnostic or other data used in your analysis. We also feel that, in the future, at least 60 days should be allowed for analysis and verification of HCFA mortality data.

Very truly yours,

Charles Morgan ART

Charles Morgan, ART
Director
Medical Records

CM: pg
Attachment
CC: Carl Brunetto, Administrator, AAGH

HCFA Health Standards & Quality Bureau
P.O. Box 26684, Baltimore, Md. 21207

210013

BON SECOURS HOSPITAL

RESPONSE TO HCFA's 1986 MORTALITY STUDY

Bon Secours Hospital is a community hospital located in southwest Baltimore City. Most of our patients live near the hospital and are elderly and poor. Because of their age and financial situation, many of our patients seek medical help late in the course of their multiple illnesses.

The HCFA report is a list of Medicare patients who expired in 1986. The average age of the patients listed in our report is 76 years old. Of the admissions classified as either high and low risk by HCFA, 83.5% of our patients were admitted with a high risk medical diagnosis. Even so, our mortality rate for these elderly patients was at the low end of HCFA's predicted range. Many of our elderly patients are admitted to the hospital with cancers and end-stage kidney disease. Bon Secours Hospital treats a large number of end-stage kidney patients. Many of these patients also come to Bon Secours to receive dialysis.

Our mortality rate for all hospital patients in 1986, including the Medicare patients, is about two-thirds less than the rate for Medicare patients alone.

Bon Secours Hospital has been committed to providing good help to those in need for many years. An important part of that good help is a comprehensive quality review program. We use many indicators in the program to help us identify opportunities to improve patient care, including mortality review. These indicators, though, are not measures of quality care - they are used to point the way to what possibly might be an area requiring further review.

Bon Secours Hospital is committed to high quality patient care. Any indication of a possible quality problem is promptly examined. If a problem is indeed identified, corrective action is swiftly taken. Our governing board and medical staff have provided the means to do this within our quality review program.

10/87

CMH
CALVERT MEMORIAL HOSPITAL

Prince Frederick, MD 20678
(301) 535-4000

October 28, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

After an intensive review of all records by both the Quality Assurance and Medical Staff, our mortality data reflects that Calvert Memorial Hospital fell within the predicted mortality rates in all categories.

Sincerely,

Peggy Naleppa, RN, C.N.A.

Peggy Naleppa, R.N., CNA
Vice President of Surgical Services
and Quality Control

PN/sm
cc:file

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Carroll County General Hospital, Inc.

WESTMINSTER, MARYLAND 21157

848-3000

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Comments on the H.C.F.A. Mortality Data/Hospital #210033

Dear Sirs:

The data submitted by H.C.F.A. indicates that all of the Medicare admissions, 144 died while in the hospital and 45 died post-hospital. Our own records indicate that 149 died in our hospital and 40 have apparently died at a later date.

We did not note any significant discrepencies in the diagnostic categories and/or codes assigned.

Thank you for sharing this information.

Sincerely,

Rosa L. Windsor

ROSA L. WINDSOR
Vice President

/ms

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	20	7	21	6
CE -- Cerebrovascular Accidents	16	3	16	3
GC -- Gastrointestinal Catastrophes	3	2	4	1
GI -- Gastrointestinal Disease	5	2	5	2
GU -- Urologic Disease	3	0	3	0
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	4	4	5	3
HM -- Severe Chronic Heart Disease	16	4	17	3
HS -- Severe Acute Heart Disease	30	3	32	1
ME -- Metabolic/Electrolyte Disturbances	6	0	6	0
OP -- Orthopedic Disorders	0	0	0	0
PN -- Pulmonary Disease	21	6	20	7
RN -- Renal Disease	3	1	3	1
SE -- Sepsis	4	3	4	2
TR -- Severe Trauma	0	1	0	1
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	13	10	13	10
Total -- All Categories	144	45	149	40
	189		189	

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

CHURCH HOSPITAL

MEDICARE PROVIDER NO. 217039

October 16, 1987

William L. Roper, M.D., Administrator
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Washington, D. C. 21201

Dear Dr. Roper:

The review of the released mortality data for Church Hospital Corporation included one (1) patient entry which could not be verified under the patient name listed. This variation may be a transposition or data entry error.

Attached you may find case specifics for your review. Thank you for your attention to this matter.

Sincerely,

Gloria Cameron

Gloria Cameron,
Sr. Vice President

GC:sb:id

Attachment

MORTALITY CASE SPECIFIC

SUMMARY:

As listed on the HCFA mortality report, the following patient name was unable to be verified; however, patient with the listed social security number, discharge date, and date of death was identified as a Church Hospital inpatient.

Patient ID Number	Surname	Diagnostic Category	Age	Sex	Adm
[redacted]		CA	67	M	8/18/86

Discharge Date	Date of Death	Principle Diagnosis
9/16/86	9/16/86	1550

Please note the name correction: [redacted]

Access 524

CHURCH HOSPITAL CORPORATION
DISCHARGE ABSTRACT

NAME [redacted] MEDICAL RECORD [redacted]

PRINCIPAL DIAGNOSIS: CONDITION ESTABLISHED AFTER STUDY TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING ADMISSION OF PATIENT TO HOSPITAL

155 0 PR DX* Hepatocellular carcinoma

SECONDARY DIAGNOSES: CONDITIONS THAT CO-EXIST AT THE TIME OF ADMISSION OR DEVELOP SUBSEQUENTLY WHICH EFFECT THE TREATMENT RECEIVED OR THE LENGTH OF STAY

571 5 DX A Cirrhosis of liver
197 8 DX B Carcinoma of intra hepatic ducts
576 2 DX C Obstructed hepatic ducts due to carcinoma
575 1 DX D Chronic Cholecystitis
599 0 DX E UTI
276 5 DX F Dehydration
285 9 DX G Anemia
276 9 DX H Electrolyte imbalance

PRINCIPAL PROCEDURE: PROCEDURE PERFORMED FOR DEFINITIVE TREATMENT RATHER THAN ONE PERFORMED FOR DIAGNOSTIC OR EXPLORATORY PURPOSES OR WAS NECESSARY TO TAKE CARE OF A COMPLICATION

08/26/86 PR PROC DATE PR SURGEON 00330
50 12 PR PROC Liver Biopsy
51 22 ( ) PR A (DAA) Cholecystectomy
87 53 ( ) PR B (DAA) Operative cholangiogram
45 13 (1) PR C (DAA) EGD
44 14 (1) PR D (DAA) Gastric Biopsy
42 24 (1) PR E (DAA) Esophageal Biopsy
88 74 (1) PR F (DAA) Ultra sound Gallbladder & Pankreas
87 64 (1) PR G (DAA) Barium Enema

1-02696 (Revised 8/86)

DORCHESTER GENERAL HOSPITAL, INC.
POST OFFICE BOX 439
CAMBRIDGE, MARYLAND 21613
(301-228-5511)

OFFICE OF THE ADMINISTRATOR

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

In reviewing the 1986 mortality information, we noted four discrepancies concerning the date of death. The following four patients died in the hospital, not after discharge as indicated on the print-out. The correct date of death is:

All of the patients diagnoses categories were verified and all were correct except one. The attending physician listed the principal diagnosis for patient [redacted] as Bradycardia which placed the patient in category HL. After reviewing the chart the principal diagonsis should have been Congestive Heart Failure, which would place this patient in category HM.

The medical records of patients who died outside of the hospital were reviewed, however no quality problems were noted. Out of the fifteen patients on the list that died after discharge, nine were transferred to chronic care facilities and one patient refused nursing home placement.

DORCHESTER GENERAL HOSPITAL, INC.
POST OFFICE BOX 439
CAMBRIDGE, MARYLAND 21613
(301-228-5511)

OFFICE OF THE ADMINISTRATOR

The medical records of patients who died in the low risk category (five patients) were reviewed. No quality problems were noted.

All deaths were reviewed as part of our quality assurance program during 1986 and 1987.

Should there be any questions about the corrections please contact Ms. Sandra Smallwood, Medical Records Director.

Sincerely,

Alan B. Malnak, Jr.
Administrator

ABM/rsg

CC: Steven Summer
Maryland Hospital Association

LELAND

Leland Memorial Hospital / P.O. Box 667 / 4401 East-West Highway / Riverdale, Maryland 20737 / 301-[illegible]

COMMENTS ON THE 1986 HCFA MORTALITY DATA
Medicare Provider #210036

October 23, 1987

Data Verification

The data used by HCFA indicates that a total of 85 Medicare patients admitted to Leland Memorial Hospital died within 30 days of admission. Of these, 75 died while still a patient at the hospital, while 10 died after discharge. Our own records indicate that of the 85 Medicare patient deaths, 77 died while still a patient at the hospital and 8 died within 30 days of discharge. (See attachment.) It is impossible to determine the percentage of patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

HCFA data indicates a total of 730 Medicare patients were admitted to the hospital while our own records indicate that there were 1,013 admissions. Presumably the discrepancy reflects multiple admissions of individual beneficiaries.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis.

Interpretive Remarks

In all of the diagnostic categories, Leland Memorial Hospital's actual mortality rate falls well within the range of predicted mortality rates. In fact, mortality rates fall below the midpoint of predicted mortality rates in the majority of diagnostic categories.

Results of Preliminary Medicare Record Review

While all of the hospital's mortality rates fall within the range of predicted mortality rates, a preliminary review has been conducted for each diagnostic category with a mortality rate above the midpoint of the predicted mortality rate.

- Severe Acute Heart Disease - HS: 27 cases, 14 deaths. 57% of the cases resulting in death developed cardiogenic shock, a condition with a national death rate of more than 90%. Twelve of the 14 cases were classified as "no codes" by their families and friends. ("No code" means that, by order of a physician, hospital staff should not attempt to resuscitate the patient in the event of death.) Of the two remaining cases, one was an 85-year-old with a history of myocardial infarction and the other was a 74-year-old with a history of myocardial infarction, arterial sclerotic cardiovascular disease and diabetes.

- Severe Chronic Heart Disease - HM: 45 cases, 12 deaths. Half of the cases resulting in death were classified as "no codes" by their families and physicians. Pre-existing serious medical conditions were present in four of the patients upon admission. Ages ranged from 65 to 90.

—more—

•Pulmonary Disease - PN: 61 cases, 14 deaths. All 14 of the cases resulting in death had four or more pre-existing serious medical conditions. Twelve of the 14 had underlying cardiac disease problems. 57% of the 14 cases were classified as "no codes" by families and physicians.

•Sepsis - SE: 16 cases, 4 deaths. Three patients had pre-existing underlying cardiovascular disease. Two patients were classified as "no codes" by families and physicians. Ages ranged from 79 to 96 years of age.

•Severe Trauma - TR: 22 cases, 4 deaths. All four cases resulting in death had pre-existing medical conditions. Two patients were classified as "no codes" by families and physicians. Ages ranged from 71 to 91 years of age.

All deaths occurring at Leland Memorial Hospital are reviewed monthly as part of a regular Quality Assurance program.

* * *

Charley Eldridge

Charley Eldridge, President

CORRECTIONS TO MEDICARE MORTALITY DATA PROVIDED BY HCFA
Hospital ID Number = 210036

Patient ID Number (HIC)	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	HCFA Date of Death	Actual Date of Death
[redacted]	[redacted]	PN	89	M	2/20/86	2/21/86	2/24/86	2/21/86
[redacted]	[redacted]	PN	84	M	2/20/86	2/22/86	2/27/86	2/22/86

MD 17.2

FALLSTON GENERAL HOSPITAL, INC. • 200 MILTON AVENUE • FALLSTON, MARYLAND 21047 • (301) 877-3700 / 879-0500

October 27, 1987

HCFA/EXEC.SEC.
'87 OCT 30 AM 10:29

William L. Roper, M.D.
Administrator
Dept. of Health & Human Svcs.
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

Fallston General Hospital has received and reviewed the schedules by HCFA detailing mortality information for Medicare patients treated in the Hospital in 1986.

As a result of this review, we make the following comments:

1. The raw data for Fallston General Hospital contain at least six coding errors and some date discrepancies. However, given the relatively large number of Medicare cases treated at the Hospital, these errors are not material insofar as the overall mortality rates are concerned.

2. The data categorized deaths by primary diagnosis (i.e., the medical condition prompting the hospital admission) and this categorization is often misleading in relation to the cause of death. Our data contained four cases that were inappropriately classified (primary diagnosis vs. cause of death) due to this flaw in methodology.

3. As related by HCFA, the 16 diagnostic groupings were selected by a panel of physician experts and this panel also selected the nomenclature describing each grouping. We found the groupings/nomenclature misleading and inappropriate for our data set. For example, severe congestive heart failure was classified as 'low risk heart disease'. While no classification system is ideal, this one is unusually inaccurate and arbitrary.

In general, although the mortality data are interesting and somewhat informative regarding the health status and longevity of this segment (i.e., over 65 years old) of the population treated by the Hospital, the Hospital-specific data are not useful and, has

been noted, are misleading. Also, we believe that, in order to improve the accuracy of mortality rate predictions, several factors must be included that were not incorporated in HCFA's model, viz:

1. The patient's medical history or the family's medical history

2. Information about cigarette smoking, drug or alcohol use

3. Information on the ratio of weight to height or other data dealing with nutrition or fitness

4. The patient's socioeconomic status including the ability of the patient to access medical care

5. The level of patient education or knowledge concerning healthcare issues and practices

6. Patient access to preventive health care services including blood pressure checks, cholesterol readings, cancer screening services, etc.

We believe that HCFA cannot predict mortality rates with reasonable accuracy without considering the factors listed above. In fact, most of the difference between actual and predicted mortality rates are not related to Hospital performance, but rather to differences in personal health habits and access to good primary and preventive health care services.

Finally, we wish to emphasize that mortality, particularly in an aged population, is not an overly helpful measurement of quality. At Fallston General Hospital, we have implemented a comprehensive peer review and quality assurance program. This program monitors more than fifty different quality indicators on an ongoing basis (among which the mortality experience is one.) Although we can appreciate HCFA's interest in educating the public about the quality of hospital services, we believe that the publication of these mortality rates, as derived from the methodology applied, fall short of the mark.

We appreciate the opportunity to provide these comments.

Sincerely,

Leonard E. Cantrell, Jr.
Managing Agent

la

The
Francis Scott Key
Medical Center

4940 Eastern Avenue / Baltimore, MD 21224
(301) 955-0100

Acute Hospital Medicare Provider No. 210029
The Mason F. Lord Chronic Hospital and Nursing
Facility Medicare Provider Number 210902

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Department of Health and Human Services
P.O. Box 26684
Washington, D.C. 20201

Dear Dr. Roper:

The Francis Scott Key Medical Center is in receipt of 1986 mortality information related to medicare patients who have been admitted to The Francis Scott Key Medical Center's short-term acute care hospital (Medicare Provider Number 210029), and we also have received mortality information related to patients admitted to our long-term care facility, The Mason F. Lord Chronic Hospital and Nursing Facility (Medicare Provider Number 210902). In correspondence that accompanied mortality data, only short-term acute care hospital information was referenced. Note, The Francis Scott Key Medical Center received, apparently in error, mortality data associated with our long term care facility. We have attached anlayses of our long-term care mortality data. See Attachment 1.

Analyses of acute hospital data reveal:

1. In the acute hospital report, HCFA has accounted for 303 deaths. We are able to verify only 301 of 303 reported. Internal review demonstrates that 1 of 303 patients listed [redacted] has never been a patient at The Francis Scott Key Medical Center. In addition, another patient [redacted] did not expire in 1986, although was a patient at The Francis Scott Key Medical Center. Our records show that this patient last visited our outpatient department in January, 1987. Also, in 9 of 301 cases reported, discrepancies in patient discharge date or expiration date were seen. See also Attachment 5A.

2. Of the 301 confirmed deaths in the acute hospital, 36 (12%) died after hospital discharge. Examination of these patients' medical records reveals that 18 of 36 patients (50%) were discharged to a nursing home (10 of 18 to our own Mason F. Lord Chronic Hospital and Nursing Facility) and 14 of 36 (39%) were considered terminally ill upon discharge from the hospital.

JOHN HOPKIN HEALT SYSTE

3. A review of mortality data for all causes and by diagnostic category reveals that the acute hospital's medicare mortality experience falls within predicted HCFA mortality ranges, with the exception of sepsis and severe trauma. A case by case analysis of all deaths related to sepsis (16 total cases) reveals that 100% of these patients (16 of 16) were admitted on an emergency basis via the Emergency Department. In addition, 12 of 16 patients (75%) were found to be terminally ill upon admission. Average age of patients was 78. A case by case review of all deaths related to severe trauma (11 total cases) demonstrates that 5 of 11 patients (45%) were admitted as a result of severe burn injuries (The Francis Scott Key Medical Center is the site of Maryland's only Burn Center).

   The Francis Scott Key Medical Center and the Mason F. Lord Chronic Hospital and Nursing Facility routinely review mortality data on an ongoing basis as part of our comprehensive quality assurance programs. Mortality data are helpful in identifying potential areas that may require further evaluation. It is important to understand, however, that mortality statistics alone may not be used as a direct measure of a hospital's quality performance. The Francis Scott Key Medical Center, for example, has several distinctive features that serve to attract a patient population with unusual severity of illness. As indicated above, The Francis Scott Key Medical Center is the home of Maryland's only Regional Burn Center. In addition, the facility, formerly named The Baltimore City Hospitals (prior to July, 1984) attracts a sicker, indigent patient population. Forty-one percent of all admissions to The Francis Scott Key Medical Center in calendar year 1986 were admitted via the Emergency Department. In contrast, HCFA medicare mortality data demonstrate that 79% of patients (239 of 301) were admitted via the Emergency Department. It is also noteworthy, that The Mason F. Lord Chronic Hospital and Nursing Facility is located on the medical center's campus in close proximity to the acute hospital and serves as an active referral source to the acute hospital. This relationship facilitates the admission of many older, chronically ill patients with poor prognosis to the acute hospital.

We are appreciative of the opportunity to review HCFA mortality information prior to publication. We believe mortality review is an important component of quality assurance efforts. In order to enhance the value of mortality statistics reporting, however, severity of illness analyses are critical in assessing the relative performance of a hospital's quality of care. We urge this refinement to HCFA statistical modeling.

If you would like additional information, don't hesitate to contact me.

Sincerely,

Judy A. Reitz

Judy A. Reitz, R.N., Sc.D.
Vice President - Nursing & Clinical Affairs

JAR/dak
Encl.

ATTACHMENT 1
Analyses of Mason F. Lord Chronic Hospital and Nursing Facility Data
Medicare Provider Number 210902

Analyses of long term care data reveal:

1. In the long-term care report, HCFA has accounted for 9 deaths. We have verified these data as correct. No deaths reported occurred post discharge. See also Attachment 5B.

2. A review of mortality data for all causes and by diagnostic category reveals that mortality rates fall within predicted ranges for all but two diagnostic categories. In each of these categories, small numbers of total cases (cancer, 2 patients, gastrointestinal catastrophes, 1 patient) render statistical analyses less reliable as the impact of random variations of outcomes in individual cases is greater.

ATTACHMENT 5 A

The Francis Scott Key Medical Center
Acute Hospital Medicare Provider No. 210029

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	22	9	22	9
CE -- Cerebrovascular Accidents	20	1	20	1
GC -- Gastrointestinal Catastrophes	8	0	8	0
GI -- Gastrointestinal Disease	6	0	6	0
GU -- Urologic Disease	9	2	6	4
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	12	1	11	1
HM -- Severe Chronic Heart Disease	20	4	20	4
HS -- Severe Acute Heart Disease	46	1	46	1
ME -- Metabolic/Electrolyte Disturbances	11	2	11	2
OP -- Orthopedic Disorders	3	0	3	0
PN -- Pulmonary Disease	37	6	36	7
RN -- Renal Disease	3	0	3	0
SE -- Sepsis	14	2	14	2
TR -- Severe Trauma	11	0	11	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	47	6	47	6
Total -- All Categories	269	34	264	37

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

ATTACHMENT 5B

The Mason F. Lord Chronic Hospital and Nursing Facility Medicare Provider Number 210902

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	2	0	2	0
CE -- Cerebrovascular Accidents	1	0	1	0
GC -- Gastrointestinal Catastrophes	1	0	1	0
GI -- Gastrointestinal Disease				
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease				
HM -- Severe Chronic Heart Disease				
HS -- Severe Acute Heart Disease				
ME -- Metabolic/Electrolyte Disturbances				
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease	1	0	1	0
RN -- Renal Disease				
SE -- Sepsis				
TR -- Severe Trauma				
OP -- Ophthalmalogic Disease				
UN -- Other Diagnoses	4	0	4	0
Total -- All Categories	9	0	9	0

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

STUDY: MORTALITY RATES ON MEDICARE PATIENTS (1986)

On review of the Frederick Memorial Hospital mortality rates provided by H.C.F.A., we are pleased to see that we are within the expected range in all diagnostic categories.

We evaluated more carefully the patients who died within 48 hours of discharge. There were only 8 patients who met this criteria. There were no surprises as all these patients had serious disease and could have been expected to die soon. In two cases: [redacted] the patient actually died in the hospital, but according to the computer printout, died one day after discharge. In both cases, the patient died near midnight and the death certificate was signed the following day.

Patients in the low-risk heart disease category generally had other complicating conditions so that their deaths were not unexpected.

While the data is interesting and can be used for some internal quality assurance studies, it is only one of many measures of a hospital's true performance.

REPLY TO H.C.F.A. 10-26-87
REVIEW PERFORMED BY: VPMA

Medicare Provider Number: 210017

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper,

Garrett County Memorial Hospital would like to make the following response to the release of HCFA mortality data:

Garrett County Memorial Hospital is dedicated to providing high quality health care to its patients and to the community. In response to the HCFA mortality data report, there are several comments which must be made:

1. The report concentrates exclusively on mortality data and assumes that this data will be used to assess the quality of care given at a particular hospital. However, there are certain flaws in the statistical analysis of this data which the public must be made aware of. The patient characteristics which are included in the analysis are limited: principal diagnosis, the presence of certain selected complicating diagnoses, sex age, the number of times that the patient was admitted to the hospital during the preceding 12 month period, and whether the patient was transferred to another hospital. But the statistical model does not include other measures such as severity of illness (i.e. how ill the patient was at the time of admission), whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, the patient's socioeconomic status, or psychological state. Without this information, the data alone can not be used as a measure of quality.

At Garrett County Memorial Hospital, we have developed an extensive Quality Assurance program to assess the care given to our patients. Mortality review is one of the aspects of the program in which every death occurring within the hospital is reviewed in detail to assure that appropriate care was provided. In addition, programs are in place to assess the care in each of the major services that the hospital provides: Medicine, Obstetrics, Surgery, and Emergency, as well as the other ancillary departments which provide patient care, such as Physical Therapy, Radiology, and Laboratory services. In each of these programs, the care is monitored and when problems are found, corrective action is taken.

2. Another area that the report fails to consider is the small sampling of admissions and deaths occurring within certain diagnostic categories. For example, for Garrett County Memorial Hospital, a 76 bed hospital, the report indicates that under the diagnostic category of Sepsis, the predicted mortality rate of which is between 15% and 78%, the hospital's mortality rate is 86%. One additional admission with the diagnosis of sepsis would reduce our actual rate to 75%, which is within the predicted range. One less death would also reduce the actual rate to within the predicted range.

3. Regarding specific review of the Sepsis category, it should be noted that each of the six patients who fell into that category had significant illness in addition to the diagnosis of sepsis. One patient had terminal cancer, three patients had pneumonia, one patient had a urinary tract infection, and one had dehydration and chronic bronchitis. In addition, three of the patients in the category were transferred to Garrett County Memorial Hospital from a nursing home, and the other three patients had end stage disease. In all cases, the patients and/or their families had requested that no heroic measures be taken.

In conclusion, we agree with HCFA's underlying theory of assessing the quality of patient care. However, it must again be emphasized that mortality is only one area in which care can be evaluated. Perhaps attention should also be directed to such areas as preventive health care programs and their effect on the quality of health in this country.

Sincerely,

Benjamin Rosenthal
Vice President for Operations

GSH THE GOOD SAMARITAN
HOSPITAL OF MARYLAND, INC.

. . . more than a community hospital

PATRICIA K SMYTH
Chairman

J A OAKEY
President

PETER V RESNICK
Vice President-Operations

HARRISON J RIDER III
Vice President-Finance

October 28, 1987

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

William Roper, MD
Administrator, HCFA
Hubert Humphrey Building, Room 309-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Roper:

Enclosed please find the response of The Good Samaritan Hospital of Maryland, Inc., to the mortality data for 1986 which was distributed to hospitals in September.

Sincerely,

Peter V. Resnick
Vice President for Operations

PVR:nvb
Enclosure

cc: Mrs. Patricia K. Smyth
Robert T. Parker, MD

The Good Samaritan Hospital of Maryland, Inc., has reviewed the HCFA mortality data for the calendar year 1986 as distributed to hospitals September 23, 1987. Review was done on all Medicare deaths that occurred in the hospital and also those who died 30 days or less after leaving the hospital.

The analysis of inpatient deaths showed that because of prognosis and age a substantial number of these deaths were anticipated by the attending physician either on admission or during hospitalization.

A review of deaths that occurred 30 days or less after discharge showed that a substantial number of those patients had a very poor prognosis and were discharged to hospice programs or nursing homes. A small number of these deaths were not trackable.

It should be noted that The Good Samaritan Hospital has in place a quality assurance program that addresses all patients regardless of payment source. This program is approved by the hospital Board of Directors and overseen by a Risk Management/ Quality Assurance Committee composed of hospital board members, medical staff members, and hospital staff. The program is coordinated on a daily basis by our Risk Manager and the Quality Assurance Coordinator. All department managers, both medical and hospital, have direct responsibility for establishing and maintaining risk management and quality assurance functions in their respective departments.

The hospital risk management/quality assurance program uses a number of quality indicators. Some of these are:

1. Mortality
2. Unscheduled returns to the operating room
3. Transfers to the intensive care unit
4. Transfers to the coronary care unit
5. Readmissions to the hospital that occur less than 15 days from the previous discharge.

It should be noted that there are many other quality indicators that are not listed in this response.

GBMC
GREATER BALTIMORE MEDICAL CENTER

Robert P. Kowal
President

(301) 828-2121

October 1, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: HCFA Mortality Data

To Whom it May Concern:

As a hospital with mortality rates below average, we think we can criticize the publication of hospital mortality rates without being discounted as defensive special pleading.

The quality of hospital care is a legitimate matter of public interest, and if government had information relevant to that interest, then the information should be released to the public. It was inevitable that public interest groups would force the publication of hospital mortality rates, if for no other reason because hospitals did not want the rates published. Now that such rates have been published, however, and now that there have been many arguments put forward explaining that such rates are not a valid measure of the quality of hospital care, it is time to ask what public purpose is served by the recurring annual publication of hospital mortality rates.

Because of the solemnity of death, it is not easy to say that these hospital mortality rates are not only not significant, they are not even interesting. It is suggested that each hospital carefully study its mortality rates. But hospitals carefully examine each hospital death, one at a time. Is a hospital to ignore unnecessary deaths because they fall within the statistical norm? Or is a hospital to criticize the people involved in inevitable deaths, because they fall outside the statistical norm? Each death matters, and the mortality rates do not change that. If a hospital community were so irresponsible as to ignore unnecessary deaths until the publication of mortality rates brought the matter of death to their attention, such a hospital should be closed. But what is the record? What has been discovered, changed or accomplished by the publication of these rates?

The measurement of the quality of hospital care is the business

6701 North Charles Street
Baltimore, Maryland 21204

Women's Hospital Fertility Center at GBMC
Charles Street

The Milton J. Dance, Jr Head and Neck Cancer Rehabilitation Center
Charles Street

The Sheila K. Riggs Radiation Oncology Service
Charles Street

The Virginia B. Sherwood Same Day Surgery Center
Charles Street

GBMC's Community and Family Health Center
1017 East Baltimore Street
Baltimore, Maryland 21202

of the Joint Commission on Accreditation of Hospitals. Review of hospital deaths is one of many requirements of the JCAH. There is no easy measurement of the quality of hospital care, and it could be argued that emphasis on hospital mortality rates distracts the press and the public from any actual information about hospital quality. The publication of hospital mortality rates does not carry an explicit claim that these rates do measure the quality of hospital care, but the implicit claim is obvious, and hospitals are left to defend themselves against the innuendo that they are irresponsibly letting people die. In the absence of convincing arguments that publication of these rates really does serve a useful public purpose, and in the absence of any evidence that previous publication of such rates has brought about any useful change, we suggest that it is sunset time for this annual awards ceremony.

Very truly yours,

Robert P. Kowal
President

cc: Maryland Hospital Association

Executive Offices

October 27, 1987

William L. Roper, M.D.
Administrator
Dept. of Health & Human Svcs.
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

Harford Memorial Hospital has received and reviewed the schedules by HCFA detailing mortality information for Medicare patients treated in the Hospital in 1986.

As a result of this review, we make the following comments:

1. The raw data for Harford Memorial Hospital contain at least five coding errors and some date discrepancies. However, given the relatively large number of Medicare cases treated at the Hospital, these errors are not material insofar as the overall mortality rates are concerned.

2. The data categorized deaths by primary diagnosis (i.e., the medical condition prompting the hospital admission) and this categorization is often misleading in relation to the cause of death. Our data contained three cases that were inappropriately classified (primary diagnosis vs. cause of death) due to this flaw in methodology.

3. As related by HCFA, the 16 diagnostic groupings were selected by a panel of physician experts and this panel also selected the nomenclature describing each grouping. We found the groupings/nomenclature misleading and inappropriate for our data set. For example, hip fractures were labeled 'severe trauma' and severe congestive heart failure was classified as 'low risk heart disease'. While no classification system is ideal, this one is unusually inaccurate and arbitrary.

In general, although the mortality data are interesting and somewhat informative regarding the health status and longevity of this segment (i.e., over 65 years old) of the population treated by the Hospital, the Hospital-specific data are not useful and, has been noted, are misleading. Also, we believe that, in order to improve the accuracy of mortality rate predictions, several factors must be included that were not incorporated in HCFA's model, viz:

1. The patient's medical history or the family's medical history

Harford Memorial Hospital

501 South Union Avenue
Post Office Box 340
Havre de Grace, Maryland 21078
(301) 939-3322

2. Information about cigarette smoking, drug or alcohol use

3. Information on the ratio of weight to height or other data dealing with nutrition or fitness

4. The patient's socioeconomic status including the ability of the patient to access medical care

5. The level of patient education or knowledge concerning healthcare issues and practices

6. Patient access to preventive health care services including blood pressure checks, cholesterol readings, cancer screening services, etc.

We believe that HCFA cannot predict mortality rates with reasonable accuracy without considering the factors listed above. In fact, most of the difference between actual and predicted mortality rates are not related to Hospital performance, but rather to differences in personal health habits and access to good primary and preventive health care services.

Finally, we wish to emphasize that mortality, particularly in an aged population, is not an overly helpful measurement of quality. At Harford Memorial Hospital, we have implemented a comprehensive peer review and quality assurance program. This program monitors more than fifty different quality indicators on an ongoing basis (among which the mortality experience is one.) Although we can appreciate HCFA's interest in educating the public about the quality of hospital services, we believe that the publication of these mortality rates, as derived from the methodology applied, fall short of the mark.

We appreciate the opportunity to provide these comments.

Sincerely,

Leonard E. Cantrell, Jr.
President/CEO

la

Theodore M. King, M.D., Ph.D.
Vice President, Medical Affairs

Johns Hopkins Health System
600 North Wolfe Street / Baltimore, MD 21205
(301) 955-2141

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards Quality Bureau
Department of Health and Human Services
P.O. Box 26684
Washington, D.C. 20201

RE: Medicare Mortality Information

Dear Dr. Roper:

Enclosed is The Johns Hopkins Hospital's response to the Medicare mortality data promulgated by the Health Care Financing Administration. These comments reflect a preliminary analysis of the data and, as indicated, these data will be incorporated into the ongoing review of hospital mortality.

We appreciate the opportunity to review and comment on the data prior to general publication.

Sincerely,

Theodore M. King, M.D., Ph.D.

TMK/crv
cc: Dr. Robert M. Heyssel
Dr. Albert H. Owens
Mr. Nicholas Porter

JOHNS HOPKINS HEALTH SYSTEM

The Johns Hopkins Hospital
The Francis Scott Key Medical Center
The North Charles Hospital
The Wyman Park Medical Center
The Johns Hopkins Health Plan
The Hopkins Preferred Network

RESPONSE TO THE HEALTH CARE FINANCING
ADNIMISTRATION'S (HCFA) MEDICARE
MORTALITY DATA RELEASE

Although mortality rates are not an absolute proxy for quality of care, the Johns Hopkins Hospital supports monitoring them in addition to other clinical indicators. In fact, we have been regularly monitoring mortality rates for all our inpatients. Thus, we were able to compare our data with HCFA's list of Medicare patients who died during 1986 at our hospital. In doing so, we found several discrepancies. The HCFA release lists 4493 Medicare patients admitted to Johns Hopkins Hospital during 1986. Our records indicate that there were 8790 separate Medicare admissions. This difference of 4217 is substantial. We are not sure how much of this difference is explained by multiple admissions for the same patients and how much by HCFA's methodology. The fact that we regularly calculate mortality rates using admissions as the denominator, whereas HCFA used patients, makes comparisons difficult. It also makes HCFA's rates higher than those which are routinely used in reporting such data.

There were a number of specific discrepancies. Of the 327 patients who were said to have died within 30 days of discharge from our hospital, we could not verify that 4 were ever admitted here. In addition, one patient was clearly alive 3 months after the stated date of death since the patient was readmitted and discharged alive again from our hospital. Of the 52 Medicare patients who were said to have died outside of the hospital within 30 days after discharge from Johns Hopkins Hospital, seven actually died as inpatients. We did not try to trace the other 45 patients to verify that they had indeed died and that their deaths were related to the reason for admission. Although none of these discrepancies may significantly alter the calculations, they make it difficult for us to verify the accuracy of the information provided.

Preliminary analysis of the available data, however, demonstrates that HCFA's mortality statistics for Johns Hopkins Hospital generally fall within the predicted range for both low and high risk categories and none of our rates is above the range. This is gratifying given the fact that our population of patients is generally more severely ill. It is recognized that the HCFA methodology has not yet sufficiently accounted for severity of illness.

Johns Hopkins Hospital will analyze some of the categories, especially CA-cancer and CE-stroke where our death rates are 5% lower than predicted and SE sepsis where the computed mortality rate is near the upper end range of the predicted mortality. In addition to these focused reviews, we will circulate the HCFA release to all our departments, so that they can incorporate these data into their ongoing review of hospital mortality.

ATTACHMENT 5

HOSPITAL = 210009 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND

Worksheet 1: Analysis of Reporting Errors

TOTAL	Diagnostic Category	Deaths Reported by HCFA In-hospital	Deaths Reported by HCFA Post-hospital	Deaths Verified by Hospital* In-hospital	Deaths Verified by Hospital* Post-hospital
56	CA -- Cancer	46	10	46	10
12	CE -- Cerebrovascular Accidents	12	0	12	0
8	GC -- Gastrointestinal Catastrophes	8	0	8	0
17	GI -- Gastrointestinal Disease	14	3	15	2
5	GU -- Urologic Disease	5	0	5	0
0	GY -- Gynecologic Disease	0	0	0	0
34	HL -- Low Risk Heart Disease	30	4	30	4
27	HM -- Severe Chronic Heart Disease	19	8	20	7
39	HS -- Severe Acute Heart Disease	35	4	36	3
5	ME -- Metabolic/Electrolyte Disturbances	3	2	3	2
0	OP -- Orthopedic Disorders	0	0	0	0
35	PN -- Pulmonary Disease	32	3	32	3
5	RN -- Renal Disease	5	0	5	0
14	SE -- Sepsis	11	3	13	1
3	TR -- Severe Trauma	3	0	3	0
0	ET -- Ophthalmalogic Disease	0	0	0	0
67	UN -- Other Diagnoses	52	15	53	13
327	Total -- All Categories	275	52	281*	45

*Includes 4 unidentified cases

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

Kent & Queen Anne's Hospital
Chestertown, MD 21620 • 301 778-3300

October 20, 1987

Medicare Provider Number 210030

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We have received the mortality information specific to our Hospital.

The information has been reviewed and we would like to comment as follows on Patient [redacted]

This [redacted] had a previous CVA with Aphasia and a previous Antero-Septal Myocardial Infarction. She had a biopsy of a benign cervical polyp on 2/22/86, was discharged on 2/25/86 and died at home on 3/7/86. Her death was unrelated to the GYN condition that was under treatment at the time of discharge.

In view of the limited number of GYN cases (6), the assignment of the death to "GYN Disease", skews the mortality rate from 0 to 17%. We would certainly wish that this specific mortality rate be corrected, prior to publication, as representing an [redacted] year old with previous CVA and Myocardial Infarction, therefore reflecting a zero mortality rate for GYN Disease.

Thank you for the opportunity to review this information prior to its publication.

Sincerely,

William R. Kirk, Jr.
Chief Executive Officer

WRK:ll

LMC Liberty Medical Center Inc.

We Do Care

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207
ATTN: William L. Roper, M.D.
Administrator

re: Hospital ID No: 210059

Dear Mr. Roper:

We would like to take this opportunity to comment on the Health Care Financing Administration's compilation of the Mortality data for Liberty Medical Center. We believe this data has the potential, if managed properly and used in context, to assist us in continuing to measure the quality of service provided to our patients.

In addition to the data supplied to us by HCFA, we engaged an independent consultant to conduct an internal collection and analysis of data to ensure valid results. If future studies by HCFA are to occur, we feel that other factors which impact on the patient's status should be taken into consideration, such as complications, socio-economic circumstances, race, and the patients condition at the time of admission.

By way of example, Liberty Medical Center's patient population and statistics illustrate the multiple illnesses and complex nature of the patients we treat. The average age for our medicare patients is 74.6 years, and this elderly group represents almost half of all the patients we treat. Our commitment to this patient population must continue.

Liberty Medical Center's Quality Assurance Program currently includes a review of all deaths. We intend to use the HCFA data, which includes deaths following discharge, because this information is being supplied to us for the first time and may assist in our continuing quality review. However, all who use the data must clearly understand that this data is all inclusive and includes non health related deaths, i.e. auto accidents, which have no relationship to hospital treatment.

We are also conducting a Severity of Illness study which will assist us with the identification of other issues and allow us to continue to improve quality. The preliminary report of the Severity of Illness study indicates that a significant percentage of the patients

were in serious condition at the time of admission. Our current experience continues to indicate that many of our patients are admitted by ambulance, through the emergency department.

We have on-going agreements with approximately 40 nursing homes to provide services to their patients. We see this as an integral part of our role. This patient population encompasses a large mix of elderly and severely ill patients. Our goal is, and continues to be, to provide the best environment possible for our patients while recognizing that their complicating illness may sometimes lead to death.

Liberty Medical Center also treats a number of patients who are suffering from complications known to be prevalent in this community. Many of our patients present with emergency illnesses, have had long term hypertension, cardiac diseases and complications which require us to treat illnesses beyond the primary condition for admission. We have and will continue to initiate programs intended to serve our patients.

The HCFA data is useful in that it encourages the continual review of the quality assurance process by our hospital. The citizens of Maryland must be given information, but it must reflect real life circumstances not statistical models. Liberty Medical Center is committed to quality and measurement indices, whose base is to enhance understanding and encourage quality. We will endeavor to give our patients our best, recognizing the circumstances and environment from which they come. We encourage your understanding of all circumstances which contribute to treating patients.

Sincerely,

William L. Jews
President

WLJ/rlw

MARYLAND GENERAL HOSPITAL

827 Linden Avenue
Baltimore, Maryland 21201
301 225-8200

MEDICARE PROVIDER NO. 21-0038

James R. Wood, F.A.C.H.A.
President

October 27, 1987

HAND DELIVERED

William M. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

This letter is in response to mortality information for Maryland General Hospital as compiled by HCFA and released to my office on September 21, 1987. We have completed our review of your information. HCFA information has been compared with similar data available to us through our internal quality assurance program which has mortality review as one of its components. Based upon HCFA methodology, our mortality rates fall within "acceptable" ranges. However, because specifications of the model developed by HCFA have not been released, it is not possible to comment on the meaning of such data.

We believe that mortality data is one screening tool available to hospitals for focusing the peer review process. However, mortality rates by themselves do not measure quality, nor should they ever be used to reach conclusions regarding quality of care. Mortality can only suggest the possibility of quality problems, not the probability. It is only through actual case review by trained hospital personnel and PRO quality and utilization review professionals that quality judgements can be made.

Quality of care is of utmost concern to the hospital's governing board, management and medical staff. Because of its importance, Maryland General Hospital provides a comprehensive ongoing quality assurance system to monitor quality of care. Any indication of a potential quality problem, including a mortality rate higher or lower than predicted, leads to a prompt investigation to determine if a problem, in fact, exists. If a problem is identified, corrective action is taken promptly.

As to an attempt to compare Maryland General Hospital to the "average" hospital as defined by HCFA, it should be noted that our patients are at times unusually complex or have characteristics not recognized by the HCFA model. Specifically, severity of illness at the time of admission was not considered in the HCFA model. Maryland General Hospital receives significant numbers of complicated referrals from specialists and other hospitals in the areas of infectious diseases, pulmonary medicine, gastroenterology and nephrology. In addition, approximately 35% of all admissions are directly from our emergency room. Also not measured by HCFA was the impact of patients transferred to the

hospital from nursing homes which is a significant portion of our activity. Another characteristic which was not included relates to general health and well-being of patients. Approximately 44% of our 1986 admissions were poor patients who, by nature of their economic situation, often have illnesses with many complicating conditions.

Actual mortality rates for a hospital could be higher or lower than predicted when such characteristics as mentioned above are considered. The importance of using mortality data as a screening tool and not a measure of quality cannot be understated. Quality can only be evaluated through a comprehensive ongoing review process.

As to specific errors in the data supplied by HCFA, we find the following:

1. [redacted] - HCFA states patient discharged 4/7/86. Patient expired 4/7/86.

2. [redacted] - HCFA states patient discharged 11/24/86. Patient expired 11/24/86.

3. [redacted] - HCFA states patient discharged 10/2/86. Patient expired 10/2/86.

4. [redacted] - HCFA states patient discharged 9/2/86. Patient expired 9/2/86.

5. [redacted] - HCFA states patient discharged 8/25/86. Patient expired 8/25/86.

6. [redacted] - Hospital entered incorrect date of death. Patient expired on 7/31/86, not 8/2/86.

As indicated by HCFA data, twelve patients expired within thirty days of discharge. Six of these patients were terminally ill with cancer and requested to be discharged to home. Four of these patients were transferred to a nursing home. The remaining two were discharged and died at home.

We appreciate the opportunity given to respond to the HCFA report. We believe review of mortality data should be a component of any process designed to review quality of patient care.

Sincerely,

J. R. Wood
President

JRW/nlf

The Memorial Hospital & Medical Center of Cumberland, Inc.
600 Memorial Avenue Cumberland, Maryland 21502 (301)777-4000

October 14, 1987

William R. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

RE: 1986 HCFA Mortality Data

Dear Dr. Roper:

The Memorial Hospital and Medical Center of Cumberland, Inc. had a total of 2,235 Medicare admissions in the sixteen diagnostic categories reviewed by HCFA. According to your data, 236 of these patients died while still patients in the hospital and 41 died after discharge. Our own records indicate that 246 of the patients died in the hospital and only 31 died after discharge. To correct your data, the names of these ten patients whose date of discharge is the same as the date of death are as follows:

It should also be noted that in those 31 patients who died at home within 30 days after discharge, the patients had proper discharge planning. The patient and/or family knew they were terminal and wanted to be at home or in a hospice unit to die, rather than in an acute care setting. This is also consistent with Medicare criteria.

The following diagnostic codes are in error:

	HCFA	MHC

The following procedure codes are in error:

	HCFA	MHC
[redacted]		

In all the diagnostic categories reviewed by HCFA, I am happy to see that we are within the range of predicted rates and this reflects the commitment that the Memorial Hospital and Medical Center of Cumberland, Inc. has towards quality care and proper utilization management.

If you have any questions, please contact me.

Sincerely,

Donald C. McAneny

Donald C. McAneny
President

DCM/cg

cc Jean Waters
Medical Director's Office
Steven J. Summer

Memorial Hospital
South Washington Street
Easton, Maryland 21601-2996

Phone 301/822-1000

MEMORIAL HOSPITAL

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, DC 20201

Re: Provider number 21-0037

Dear Dr. Roper:

In reviewing the Medicare discharge data for Memorial Hospital at Easton, significant discrepancies between HCFA data and that derived from our records were noted. These are tabulated below:

	NUMBER OF CASES		NUMBER OF DEATHS		% DEATHS	
Diagnosis	HCFA	MH@E	HCFA	MH@E	HCFA	MH@E
Cancer	178	233	49	59	28	25
Severe Chronic Heart Disease	133	187	32	33	24	18
Metabolic/ Electrolyte	32	47	9	9	28	19
Sepsis	13	20	9	10	69	50

Our records are based on Medicare billing data. Patient with multiple stays for same disease category during calendar year 1986 were only counted as one case. Cases were selected by discharge date, payor and your criteria for principle ICD-9 code or DRG.

As can be seen from the chart, the discrepancies in the number of cases significantly distorts our mortality rates. We have reviewed our experience with the principle ICD-9 code & DRG's. Our data includes discharges for these

VHA Partner–VHA Mid-Atlantic Affiliate of the Voluntary Hospitals of America System.

diagnoses even if an admission occurred later in the year for an unrelated condition. We believe that this accounts for the differences and more accurately represents our experience in managing such problems.

Sincerely yours,

Nick Rajacich
President

NR/pkf

cc: Mr. Steve Summer, Maryland Hospital Association
Richard Manegold, M.D.
Miss E. Ann Bishop
Mrs. Vivian Brotman
Mr. William Wojcik
Mrs. Dorothy B. Hearne

The
North Charles
Hospital

North Charles and 28th Streets / Baltimore, MD 21218
(301) 338-2000

October 20, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Department of Health & Human Services
P.O. Box 26684
Washington, D.C. 20201

Re: Medicare Mortality Information

Dear Doctor Roper,

The North Charles Hospital is in receipt of 1986 mortality information related to Medicare patients who have been admitted during 1986. We have carefully reviewed the information presented. Analyses of data reveal:

1. H.C.F.A. has accounted for 124 deaths in our Medicare admitted population. These 124 deaths represent 69.3% of our total deaths of 179 in 1986. It should be noted that Medicare patients represented 37.9% of our total admissions in 1986. We have confirmed the name list and believe it is favorable that all deaths fell within the range of predicted mortality values.

2. There appears to be an error in the stated number of Medicare admissions in 1986. Your data reflects 1,288 cases. In fact there were 2,540 Medicare cases in a total of 6,706 admissions. A similar discrepancy has been found at other Hopkins system hospitals. We are not sure how much of this difference is explained by multiple admissions for the same patients and how much by H.C.F.A.'s methodology. Based on admissions, our mortality rates are lower because of the larger denominator.

3. Of the 124 confirmed deaths, 26 had dates of discharge different from the date of death. Examination of this specific cohort revealed:

   2 actually died in the hospital and dates were in error
   12 died at home
   1 died in another general hospital
   1 died in a skilled nursing home
   6 died in an intermediate care facility
   4 died at sites still not determined

JOHNS HOPKINS HEALTH SYSTEM

The North Charles Hospital Medical Staff Committees review every death on an ongoing basis and specific cases are further reviewed by Departmental and Hospital-wide Q.A. committees. We are appreciative of this opportunity to review H.C.F.A. mortality information prior to publication.

If you should wish for additional information, please contact me directly.

Sincerely,

Irwin P. Bloom
President

IPB/kwb

cc: Theodore King, M.D.,
V.P., Medical Affairs, Johns Hopkins Health System
Steven J. Summer,
Maryland Hospital Association

Parkwood Hospital

8910 WOODYARD ROAD
CLINTON, MARYLAND 20735

(301) 868-2700

Medicare Provider #: 210047

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for your letter of 9/21/87 regarding Hospital Mortality Information on Medicare patients, and for giving us an opportunity to review and comment on the report. Recognizing that the data has certain limitations, i.e. lacks information on patients severity of illness, our review findings and conclusions were formulated based upon information contained in the medical record. At this time, we would also like to point out that the smaller the number of admissions, the less reliable are the statistics, as the impact of random variation of outcomes in individual cases is greater.

Hospital Review Findings:

1. Our Medical Staff and Hospital personnel found the HCFA data informative and educational. It reflects on the types of cases we admit.
2. The identified cases were hospitalized at our facility and were discharged when they were medically stable or were transferred to a Medical Center for services that cannot be provided by our hospital. Their deaths occurred after they were discharged.
3. In addition to the condition primarily responsible for their hospital stay, the patients also had multiple medical problems. They were older and sicker. For example, one patient who was admitted for a stroke also needed to be actively treated for kidney failure.
4. All of their admission diagnoses fell within HCFA's guidelines of High Risk Conditions.
5. [redacted] the diagnostic category should be corrected from UN (All Other Conditions) to CE (Stroke) since the principal diagnosis is cerebrovascular accident.

Hospital Conclusion:

1. During their hospital stay, the patients were managed in a manner consistent with the practice of good medicine.
2. Given the patients' medical problems (reason for admission and pre-existing conditions), they were not expected to survive. Death was the eventual outcome of their progressing disease processes.

If we can be of further assistance concerning this matter, please do not hesitate to call us.

Sincerely,

May Sarmiento, R.N.
Administrator

cc: Hospital Board of Directors
Medical Executive Committee Members
Maryland Hospital Association

PHYSICIANS MEMORIAL HOSPITAL

October 28, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Ref: Physicians Memorial Hospital
Medicare Provider #210035

DELIVERED BY HAND

Dear Doctor Roper:

The following are Physicians Memorial Hospital's official comments regarding mortality data for Medicare beneficiaries in 1986.

Physicians Memorial Hospital supports the public disclosure of the Medicare mortality data. It should be additionally noted that this data is only one method of evaluating the quality of hospital care. Our hospital participates with the Joint Commission on Accreditation of Healthcare Organizations, which requires hospitals to meet other standards for evaluating quality care in addition to mortality rates. Physicians Memorial Hospital is also presently engaged in a two-year, state-wide quality indicator project with other hospitals in the state of Maryland. Of the ten quality indicators developed for this project, mortality rates are only one component of the evaluation. Another aspect of our overall assessment of quality of patient care is to conduct monthly reviews of mortality cases by each of our clinical departments. The hospital also has ongoing programs for Utilization Review, Risk Management, and Infection Control. The medical staff also has several committees to evaluate patient care as follows: Tissue & Transfusion Committee, Pharmacy & Infection Control Committee, Credentials Committee, Critical Care Committee, Trauma Committee, and Quality Assurance Committee.

The Health Care Financing Administration (HCFA) has stated to the hospitals that they have done their best to eliminate any discrepancies in the data or the computer programs used to analyze

this information and has requested hospitals to verify the accuracy of the information presented to the hospitals. In our preliminary verification process, there were 100 Medicare patients reported dying in the hospital for 1986/1987. Of these patients listed as dying in 1986/1987, one died in 1982. Of 24 patients listed as dying within 30 days of hospital admission for 1986/1987, 6 of these patients died at the hospital. These errors do not significantly change our actual mortality rate or range of predicted mortality rates.

Physicians Memorial Hospital will continue to analyze the information presented, in addition to the other existing mechanisms listed above for evaluating patient care.

Thank you for your attention to this matter.

Very truly yours,

Robert T. Jetland
Administrator

Sacred Heart Hospital

P.O. Box 539 900 Seton Drive Cumberland, Maryland 21502 301-759-4200

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper,

Thank you very much for the opportunity to comment on the data that will be published regarding Sacred Heart Hospital. Enclosed is a copy of our response which we would appreciate having printed with our data.

We certainly appreciate HCFA's efforts to begin to do some data analysis, but would much prefer that it would be handled in a way that would not imply that this was a definitive measurement by an outside agency of the quality of care in an institution.

Thank you again for your willingness to accept our comments.

Sincerely,

Sister Carol Keehan
President

SCK/es

Enclosure

Sacred Heart Hospital

P.O. Box 539 900 Seton Drive Cumberland, Maryland 21502 301-759-4200

Sacred Heart Hospital, Cumberland, MD
Comments regarding HCFA Mortality Data

The hospital was pleased to note that all categories measured by HCFA were within the predicted mortality range. The information presented by HCFA is helpful but certainly not a valid, conclusive indicator of quality care.

There are significant data limitations:

1. One of the major deficits of the data base is that it is limited to Medicare patients. This limitation generates invalid assumption regarding a diagnostic category for all hospital patients.

2. The major problem in the data presented by HCFA is the lack of adequate measure of severity of illness.

3. Some of the data concerning Sacred Heart Hospital is incorrect. At least in the patients that could be identified, a 10% error rate in the date of death for those who died after discharge was found.

4. In the trauma category, 66% of the patients identified were patients with fractured hips with an average age of 87 years. These could more properly be classified in the orthopaedic category. Of these patients, 33% died of cancer, not of a fractured hip. This obviously is a category where more data refinement is needed.

5. Although within the predicted mortality rate, cancer patients are in the high normal due to Sacred Heart Hospital having the only hospice unit in the tri-state area in 1986. The presence of such a unit is a variable not built into HCFA measurement system. These are patients who come to the hospital for assistance in the dying process and their inclusion in the statistics obviously distorts them.

6. The patient identifying information supplied by HCFA to hospitals made verifying the data difficult and in some cases impossible.

Finally, while HCFA's efforts to begin data analysis are helpful, they should never be presented or interpreted as a valid measure of quality, a much more complex task which includes other numerous indicators.

Quality assurance programs are becoming more comprehensive and refined with each passing year. Our hospital diligently monitors the appropriate indicators which reveal a more complete picture of the overall quality of care rendered. Careful evaluation and analysis of the entire data base generated by the Quality Assurance Program gives to the responsible person in each hospital a more valid view of this process.

SINAI
HOSPITAL OF
BALTIMORE

Executive Offices
301/578-5678

October 28, 1987

Medicare Provider Number 21T012

COMMENTS ON THE HCFA MORTALITY DATA
SINAI HOSPITAL OF BALTIMORE

Data Verification

The data used by HCFA indicates that a total of 378 Medicare beneficiaries admitted to Sinai Hospital of Baltimore died within thirty days of admission. Of this number, 327 are reported to have died while still a patient in the hospital and 51 dying after discharge.

Our records indicate that 5428 Medicare admissions occurred in 1986. In the designated sixteen diagnostic categories HCFA records 2242 Medicare admissions; Sinai data reflects 3651 Medicare admissions. It is assumed that the higher number of admissions reflected by Sinai Hospital's data is the result of multiple admissions of Medicare beneficiaries; HCFA data using only the final admission.

Our data analysis indicates the following discrepancies:

- Two patients were admitted to Sinai Hospital on dates subsequent to the dates of death listed by HCFA. Our records indicate that these patients were then discharged alive.

- One patient was a duplicate entry, both entries with the same name and HIC number but with different dates of admission and death, different age and sex.

- Date of admission incorrect for two patients. Date of death would be after the thirty day period.

- Date of admission and death incorrect on one patient. Admission and death occurred approximately sixty days after those listed by HCFA.

- Of the 51 cases listed as having died after discharge:

  Five patients were transferred to other acute general hospitals for treatment.

  Eight patients listed as dying after discharge died while still inpatients. The dates of death were incorrect.

It is impossible to determine the percentage of the remaining 38 patients listed as dying after discharge who may be alive, as the information concerning death after discharge is not available to us.

Some coding errors were identified. Without more detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is not possible to verify the accuracy of the diagnostic or other data used in the HCFA analysis.

Interpretive Comments

In two of the diagnostic categories, Sinai Hospital's mortality rate falls outside of the range of the predicted mortality rate, one category above and one below.

In the diagnostic category of Sepsis (SE), Sinai is reported as having 52 cases, 32 deaths and an actual mortality rate of 62% while the predicted rate is 27 to 56%. Sinai's analysis shows the following errors:

- One case listed twice.

- Three cases miscoded.

In addition, Sinai's data documents that there were 67 patients coded to DRG 416 and 417 and 34 deaths. Using these figures, Sinai Hospital's actual mortality rate is 50.7%, within the predicted mortality range.

Our analysis further shows that 23 of the patients identified in the HCFA listing were 75 years old or older, with 9 over the age of 90. Approximately 50% of the patients were admitted from nursing homes. 70% of the patients had comorbid conditions and 13 of the patients died within 3 days of admission. The Systemetrics Disease Staging System, indicating severity of illness, was applied to all patients' records coded to this category. Each patient staged between a level three and four with all mortalities being 4. Our medical record review and analysis indicated that these patients were very elderly, high risk patients, who were seriously ill on admission and in whom death was not unexpected.

Sinai Hospital believes that it should be emphasized that this data should not be used as the sole basis for judging quality of care provided by a hospital. Rather it should be used as an indicator that helps focus quality assurance activities.

A detailed listing of the data discrepancies is attached.

SINAI
HOSPITAL OF
BALTIMORE

Executive Offices
301/578-5678

Medicare Provider Number 21T012

DATA DISCREPANCIES
SINAI HOSPITAL OF BALTIMORE

	Patient ID Number (HIC)	Surname	Dgnstc Ctgry	Age	Sex	Date of Admit	Date of Discharge	Date of Death
1.	[redacted]	[redacted]	CA	070	F	3/18/86	3/19/86	3/29/86
	Sinai data					9/01/87	9/06/87	?
2.	[redacted]	[redacted]	CA	080	F	7/07/86	7/16/86	7/19/86
	Sinai data					7/28/86	8/01/86	?
3.	[redacted]	[redacted]	HS	094	F	7/09/86	7/10/86	7/10/86
	Sinai data					9/16/86	9/25/86	9/25/86
4.	[redacted]	[redacted]	HS	078	F	3/28/86	3/31/86	3/31/86
	Sinai data					3/17/86	3/18/86	?
5.	[redacted]	[redacted]	SE	068	M	6/30/86	7/03/86	7/03/86
	[redacted]		SE	071	F	4/02/86	4/10/86	4/10/86
	Sinai data							
	[redacted]	[redacted]		068	M	6/30/86	7/03/86	7/03/86
6.	[redacted]	[redacted]	UN	065	F	2/14/86	3/14/86	3/14/86
	Sinai data					2/09/86	2/20/86	?
7.	[redacted]	[redacted]	HL	093	F	12/28/85	1/24/86	1/24/86
	Sinai data					12/22/85	1/24/86	1/24/86
8.	[redacted]	[redacted]	HS	081	M	10/30/86	11/05/86	11/23/86
	Sinai data					Transferred to Washington Hospital Center		
9.	[redacted]	[redacted]	HL	081	F	10/16/86	10/28/86	11/15/86
	Sinai data						Transferred for CABG	
10.	[redacted]	[redacted]	HL	086	F	3/21/86	3/28/86	4/15/86
	Sinai data					Transferred to Johns Hopkins Hospital		

DATA DISCREPANCIES
SINAI HOSPITAL OF BALTIMORE

	Patient ID Number (HIC)	Surname	Dgnstc Ctgry	Age	Sex	Date of Admit	Date of Discharge	Date of Death
11.	[redacted]	[redacted]	ME	066	F	10/24/86	10/25/86	10/31/86
	Sinai data					Transferred to University of Maryland Hospital		
12.	[redacted]	[redacted]	HL	071	F	5/05/86	5/23/86	5/28/86
	Sinai data					Transferred to St. Josephs Hospital		
13.	[redacted]	[redacted]	UN	084	F	8/05/86	8/05/86	8/31/86
	Sinai data					8/05/86	8/05/86	8/05/86
14.	[redacted]	[redacted]	ME	075	F	10/09/86	10/16/86	10/31/86
	Sinai data					10/09/86	10/16/86	10/16/86
15.	[redacted]		SE	079	M	6/30/86	6/30/86	7/11/86
	Sinai data					6/30/86	7/11/86	7/11/86
16.	[redacted]	[redacted]	HL	079	M	12/10/86	12/11/86	12/12/86
	Sinai data					12/10/86	12/11/86	12/11/86
17.	[redacted]	[redacted]	HM	082	M	9/05/86	10/04/86	10/05/86
	Sinai data					9/05/86	10/04/86	10/04/86
18.	[redacted]	[redacted]	UN	094	F	9/22/86	9/24/86	9/25/86
	Sinai data					9/22/86	9/24/86	9/24/86
19.	[redacted]	[redacted]	SE	090	M	6/09/86	7/05/86	7/06/86
	Sinai data					6/09/86	7/05/86	7/05/86
20.	[redacted]	[redacted]	UN	073	F	7/10/86	7/11/86	7/12/86
	Sinai data					7/10/86	7/11/86	7/11/86
21.	[redacted]	[redacted]	HS	064	M	12/28/86	12/29/86	12/29/86
	Sinai data					12/28/86	12/28/86	12/28/86

SOUTHERN MARYLAND HOSPITAL CENTER
7503 SURRATTS ROAD • CLINTON, MARYLAND 20735 • (301) 868-8000

October 28, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Medicare Provider # 21-0054

Dear Dr. Roper:

The data used by HCFA indicates a total of 297 Medicare patients admitted to Southern Maryland Hospital died within 30 days of admission. Of these, 267 died while still an inpatient of the hospital and 30 died after discharge.

Our records, however, indicate that one (1) of the patients included in your listing was still alive more than 30 days post admission as verified by the date of death recorded in the patient's medical record, and therefore should be excluded. We have, therefore, recalculated the actual mortality rate in the Urologic disease diagnostic category to be 6.1%, rather than your rate of 7.0%.

In the diagnostic category of Severe Chronic Heart Disease (HM), significant factors influencing the risk of death, as well as, certain patient characteristics were not adequately reflected or considered in the HCFA Model and thus portray a misleading picture of our mortality rate.

In the HM category, thirty-five (35) of the forty-five (45)patients who expired were emergency admissions with twelve (12) dying within 24-48 hours of admission. Additionally, 22 of these patients had "Do Not Resuscitate Orders", and 23 patients coded. Special procedures were performed on 19 patients and death was the expected outcome in 24 of these cases with ages ranging from 80 through 90 years. There was an unusually high number of complications and/or comorbid conditions that were not accounted for in the HCFA Model. As an example, there were 89 additional qualifying ICD 9 CM severity codes which were recorded in the medical record, but not considered by HCFA. Therefore, the estimation of the relative effect of severity of illness in determining the predictable mortality rate for these patients was inaccurate.

It should also be noted that patients who reside in Southern Maryland for whom we provide care as a regional referral center can be expected to be at higher risk for severe chronic heart disease as a result of their environmental hazards, i.e. tobacco farmers who are heavy smokers are predisposed to severe chronic heart disease.

Southern Maryland Hospital serves as a regional radiotherapy referral center for cancer patients. Therefore, a higher than predicted mortality rate can be expected in this category. Terminally ill cancer patients, both inpatients and outpatients, are treated with radiotherapy, subsequently discharged and cared for at home only to be admitted to the hospital when close to death.

Of the 49 cancer patients included in the HCFA Model, 44 were terminally ill upon admission, and were admitted from home, and had "Do Not Resuscitate Orders"; 22 of these were emergency admissions.

Of these 49 patients, 90% had an unusually high number of complications and/or comorbid conditions that were not accounted for in the HCFA Model; 120 additional qualifying ICD 9 CM severity codes were assigned and recorded in the medical record which were not considered by HCFA in preparing the analysis. Thus the estimation of the relative effect of the severity of illness in determining the predictable mortality rate for these patients was inaccurate.

In summary, the HCFA analysis rests on the assumption that the patients admitted to all hospitals who subsequently expire within 30-days of admission are similar except with respect to the specific characteristics included in the model. In the category of HM and CA, Southern Maryland Hospital does not treat an average mix of patients as explained in our comments. Consideration must also be given to the diagnostic state of the art services Southern Maryland Hospital provides in an effort to accommodate the medical needs of it's community, and serving as the regional referral center for Trauma patients and terminally ill cancer patients.

Sincerely,

Sebastian L. Suriani
Executive Vice President
Southern Maryland Hospital Center

Enclosure

St Agnes Hospital

Office of the President

October 23, 1987

William L. Roper,M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Informaiton
P. O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

We have reviewed the information provided to us by the Health Care Financing Administration on St. Agnes Hospital's Medicare experience regarding patient mortality and would like to provide comments on certain elements of the report. We would like to focus our comments in four specific areas; those being

1. THE SUMMARY REPORT
2. SELECTION OF DATA
3. POST-DISCHARGE DEATHS
4. GENERAL COMMENTS

SUMMARY REPORT:

The summary report, as provided, was not complete, therefore, a hand count of all the data was necessary to check the consistency of the report. Specifically, of the seventeen categories of patients given in the detailed section of the report only sixteen were on the Summary Listing. The "UN" meaning (other) category was not included. Also, totals of expired patients were not given which was unusual since the topic of this report is mortality.

SELECTION OF DATA:

One of the seventeen categories in the report (sepsis) was identified by DRG. The remaining categories were given by diagnosis and certain complication or co-morbidity codes,ICD-9 codes. Since most analyses in hospitals currently are being done by DRG, it would be appropriate to have all categories listed by DRG. This would enable hospitals to monitor the death rates within certain DRGs on an on-going basis in the future.

POST-DISCHARGE DEATHS:

The appropriateness of including patients who expired post-discharge to hospitals is questionable. The hospital was not in a position to give the patient final care, has no access to the cause of death and therefore has no information on final diagnosis. Confirmation of the accuracy of the final diagnosis is very cumbersome. It is not appropriate to assume that the discharge diagnosis from the last hospital stay would consistently be the final diagnosis and, therefore, cause of death. Contacting attending physicians or nursing homes to confirm the information on deaths of discharged patients assumes the hospital is aware of the death. This is not an accurate assumption. The hospital has no way of including these deaths in any of its quality assurance activities. Therefore, there is little, if any, possibility to affect the outcome or determine whether the outcome was related or unrelated to the hospital stay.

GENERAL COMMENTS:

The statistical model developed by the Health Care Financing Administraton, whether favorable or unfavorable to hospitals for 1986, does not take into account a number of factors which may come into play in hospital mortality rates in the future. For example, the geographic gravitation toward regional health care centers by more severely ill patients may cause mortality rates to increase from one year to another as hospitals become more geographic in their focus. Other factors, not represented in the statistical model, are such things as severity of illness, stage of disease, psychological status of the patient, family support, etc. These factors have an impact on patient outcomes in a way which cannot necessarily be established through statistical modeling and clearly these factors are not taken into consideration in the statistical model developed to collate this data, nor in the DRG system as a whole.

Finally, raw data on hospital mortality is not a measure of quality of care in any hospital. This data is a component, along with many other components, that is used in quality assurance measurements to determine a standard of care a hospital provides to its patients and the communities that it serves.

We are pleased to have the opportunity to respond to the mortality data for our hospital and find the results to be consistent with our internal quality assurance standards.

Sincerely,

Sister Mary Louise

Sister Mary Louise Lyons
President

SML:gd

SAINT JOSEPH HOSPITAL

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

I would like to start this letter, which contains the comments from Saint Joseph Hospital, Towson, Maryland, on the HCFA mortality statistics, by applauding HCFA for its concern about the quality of care for Medicare patients and for soliciting comments from hospitals on the hospital-specific statistics. As you know, mortality information is only one statistical indicator of quality of care and does not provide a detailed analysis of severity of illness of the patients treated, the scope of services provided by the individual hospitals, and the appropriateness and the quality of care provided.

The comments contained in this letter are only pertinent to the diagnostic category of Pulmonary Disease because this is the only category of the sixteen Medicare diagnostic categories that Saint Joseph Hospital falls outside of the range of predicted mortality rates. All 60 medical records of the patients listed as Medicare deaths were submitted to extensive peer review by the Department of Medicine and the information obtained from this review has been integrated into the Quality Assurance Program at Saint Joseph Hospital.

The specific comments listed below are summary in nature and are substantiated by documentation available at Saint Joseph Hospital. These specific comments are as follows:

1. There are 60 patient names listed in the Pulmonary Disease diagnostic categories, and with a total of 220 patients in this category, the percentage of mortality is 27% and not the 29% reported by HCFA. This discrepancy in percentages is important because the HCFA range of predicted mortality rates is 14% to 27%.

2. The severity of illness for patients in this diagnostic category is very high because Saint Joseph Hospital is a referral institution for many Nursing Homes which service the geriatric population. For example:

   a. Twenty-three of the total 60 deaths were not expected to live and were identified as non-resuscitative patients.

A member of the Franciscan Health System Founded 1864

(Continued)

b. Ten of 60 patients who died were admitted from nursing homes.

c. The median age of the 60 patients is 79 years old.

d. Seven of the 37 patients who did not have a "do not resuscitiate" order were treated in the Intensive Care Unit with ventilatory support.

e. Many of the 60 patients who died had a large number of complications contributing to their death in addition to the pulmonary infection, namely, in addition to a malignancy or dementia, renal failure, congestive heart failure, and advanced coronary artery disease. Many patients even had prior bypass surgery with life threatening arrhythmias, interstitial pulmonary fibrosis, prior or concomittant strokes with significant neurologic impairment, and adult respiratory distress syndrome.

3. There is absolutely an absence of any pattern of death by physician as no one physician was involved in the treatment of any two patients.

In summation, I am personally gratified with the care that the patients received at Saint Joseph Hospital who were treated in the diagnostic category of Pulmonary Disease. Pulmonary disease by nature is a difficult disease to quantify expected percentage of death because pneumonia historically is the principal or contributing cause of death to patients with underlying debilitating disorders. It should be remembered that patients with cancer and dementia often die of respiratory death. The coding rules indicate that when such patients are admitted with anemias, dehydration or pneumonitis associated with malignancy this complication is the principal diagnosis, not the underlying disorder that in fact led to the ultimate death.

Once again, thank you for the opportunity to comment on the H.C.F.A. statistics.

Sincerely,

S. Marie Cecilia, osf

Sister Marie Cecilia, O.S.F.
President

SMC:sbm

SUBURBAN HOSPITAL

Suburban Hospital

8600 Old Georgetown Road
Bethesda, Maryland 20814
Telephone 301 530-3100

Medicare Provider #210022

October 21, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Roper:

Enclosed please find Suburban Hospital's comments on the HCFA mortality data. Please attach this statement to the December publication of the mortality data.

Thank you for providing us with the opportunity to review and comment on the mortality data.

Sincerely,

Joan Finnerty /cg

Joan Finnerty
President

JF:me

Enclosure

Medicare Provider #210022

SUBURBAN HOSPITAL'S COMMENTS ON HCFA'S MORTALITY STATISTICS

We at Suburban Hospital appreciate the opportunity to review and comment on the HCFA's mortality statistics for our hospital.

We carefully checked HCFA's mortality statistics against our records and have found only minor errors in some dates of admission. Therefore, we have concluded that the HCFA information is, for the most part, accurate.

We would like to comment on several issues regarding the HCFA mortality data.

First, we feel that mortality must be viewed in the context of an overall quality assurance program. Mortality in and of itself is not necessarily a measure of quality of care, but, rather, one useful indicator to be studied when reviewing the over all quality of care.

At Suburban Hospital we have a comprehensive hospital-wide quality assurance program. In addition to mortality, all infections, all post operative complications, and many other indicators are studied and analyzed on a continuous basis by the hospital's Medical Staff and Administration.

Second, the mortality statistics as presented by HCFA are basically raw data, unadjusted for severity of illness, although age, sex, morbidity, and certain other factors have been considered. We feel that these statistics should not be used to make comparisons between hospitals, although they do represent useful data for further quality of care studies by each hospital.

Third and last, we recognize and agree with the need for consumers to have information about quality of care. We support the release of information; however, we would like to caution the public against using these mortality statistics as the sole measure of quality of care. In this regard we would like to suggest that the release of the HCFA mortality statistics be accompanied by a statement from HCFA expressing the limitations of the data.

UNION HOSPITAL
OF CECIL COUNTY
ELKTON, MARYLAND 21921
301/398-4000

October 22, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

ATTN: William L. Roper, M.D.
Administrator

Dear Dr. Roper:

The review of the charts involved in this data retrieval report showed that there were four patients who were categorized as having died with pneumonia. They did, but the underlying illnesses, cancer, stroke, alzheimer's disease, were so severe that one would have expected them to be the primary category with pneumonia a terminal complication. If we were to put those cases into what we consider to be more "appropriate" categories, it wouldn't change the fact that all the mortalities fell into the "expected mortality" range.

One of the patients [redacted] credited to Union Hospital of Cecil County actually was transferred to Christiana Medical Center and died there. Also, one of the patients [redacted] died four weeks later than the HFCA data indicates, and so should not have been included in this report. (The patient expired on 8/20/86 rather than on 7/28/86.)

Respectfully,

UNION HOSPITAL OF CECIL COUNTY

Henry Farkas, MD

Henry Farkas, M.D.
Physician Advisor

HF:lsc

MEMBER:
AMERICAN HOSPITAL ASSOC.
MARYLAND HOSPITAL ASSOC.

APPROVED BY:
THE JOINT COMMISSION ON
ACCREDITATION OF HOSPITALS

THE UNION MEMORIAL HOSPITAL

201 East University Parkway
Baltimore, Maryland 21218
(301) 554-2000

October 27, 1987

William L. Roper, M.D.
Department of Health and Human Services
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for providing us with the opportunity to review and comment on the Hospital Specific Mortality Data. Although The Union Memorial Hospital data indicates that our "Actual Mortality Rate" fell either below or at the low end of the "Range of Predicted Mortality Rates", we have several concerns regarding the public interpretation of such reports.

1) Data Regarding Deaths Occurring After Hospitalization is Inaccurate and Misleading: The mortality data for all hospitals implies a relationship between hospitalization and death within thirty (30) days. This may or may not be true, depending on the facts of particular cases. In the brief time we have had to review our data, it appears that the HCFA data has significant inaccuracies as to when and where the patients died. Furthermore, factors which may be totally unrelated to hospitalization can considerably skew the results.

2) The Data does not Reflect Severity of Illness: The patient's general health at the time of admission and the presence of co-existing diagnoses can impact outcomes. This lack of qualifiers in the published data will unfairly alter the public perception of the quality of care.

3) Categorization of Body Systems Without Identifying the Specific Conditions is Misleading: It is of interest to note, for example, that a skull fracture and injury to intra-abdominal organs are not included in the Severe Trauma (TR) category; similarly Urologic Disease (GU) excludes kidney calculus.

4) We have found some discrepancies in regard to codes and deaths in and out of the hospital, but these findings have to be further verified. The amount of turn-around time between the release of HCFA data to the hospital and our response is inadequate. Although Union Memorial has

and will continue to review all deaths within the hospital, it is impractical for a large hospital to verify and study deaths occurring after hospitalization within the thirty (30) day response period.

The Union Memorial's mortality data confirms our belief that we provide high quality care. However, we also believe that a further refinement of the HCFA data and the processes relating to the release of the information are necessary to bring about credibility.

Sincerely,

Jean B. Finney

Mrs. Redmond C.S. Finney
Chairman of the Board

Richard A. Reif Jr.
President

Karim F. Rashad, M.D.
Chief of Staff

University of Maryland Medical System
University of Maryland Hospital

MEMORANDUM

To: Health Care Financing Administration
Health Standards and Quality Bureau

From: Frank A. Appel
Director, Quality Management & Medical Staff Affairs

Date: October 26, 1987

Subject: **HOSPITAL MORTALITY DATA**

Attached are comments from the University of Maryland Medical System for inclusion in the public release of hospital mortality data.

Although at this time we have reviewed only a proportion of the cases in our sample, we thought it would be useful to inform you that we have found:

1. a 3.3% error rate in date of death, although in all cases so far the correct date still occurred within 30 days of admission, and

2. an 8.2% error in principal diagnosis codes; in 4.9% of the cases reviewed, the correct principal diagnosis code would have placed the patient in a different diagnostic group.

We hope that these findings, albeit incomplete, are useful to you in evaluating the methodologic issues underlying this effort.

Attachment

University of Maryland Medical System
University of Maryland Hospital

MEDICARE PROVIDER NO. 210002

COMMENTS ON MORTALITY DATA

The University of Maryland Medical System supports the effort by the Health Care Financing Administration to provide comparative data on health care outcomes. Analysis and discussion of such data can only lead to improved quality.

Before commenting on the findings, we offer one suggestion concerning the process. The ability of each hospital to review these data is limited in that a listing of only the numerator cases (deaths) is provided, while the remaining cases in the sample are not identified. Since the method used to choose the sample was unique, hospitals cannot easily identify the cases included. A meaningful analysis to find ways to improve quality would require review of at least some of the cases who did not die, not just those who did. Providing a list of all cases in the sample would be more helpful to hospitals.

Examining comparative mortality data can identify ways of improving quality; nevertheless, differences in mortality rates do not themselves indicate differences in quality. Differences in mortality are often the result of different services provided by hospitals or differences in severity of illnesses treated. The methodology used by HCFA does not take into account either of these factors. The University of Maryland Medical System, for example, is a state-wide referral center for many high risk diseases. UMMS houses the nationally known Shock Trauma Center, the hub of the state-wide emergency medical services system, and as a result UMMS treats a high proportion of the severest traumatic injuries. For example, nearly 80% of all spinal cord injuries and 70% of head injury cases in the state are treated at ShockTrauma. The University of Maryland Medical System is also a regional referral center for orthopedic, neurosurgical, cardiac, and cancer care, as well as obstetrics and neonatology. As a result, higher mortality rates in certain categories would be expected at University of Maryland Medical System when compared to the "average" hospital.

Our analysis of the data provided by HCFA verifies that the instances of higher than predicted mortality rates can be explained by regional referrals of severely ill patients to specialty services at the University of Maryland Medical System.

The various peer review committees at University of Maryland Medical System routinely review mortality information along with a variety of other, perhaps more useful, indicators of quality as part of our ongoing monitoring and evaluation of the quality of care provided by University of Maryland Medical System.

UNIVERSITY OF MARYLAND

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS

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JOHN H. SIEGEL, M.D.
Professor of Surgery
Director, MIEMSS Clinical Center
Deputy Director, MIEMSS

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
Room 309-G
200 Independence Ave., S.W.
Washington, DC 20201

Dear Doctor Roper:

After having reviewed the recently published summary description of the Regression Based Analysis of Medicare Hospitality Mortality Data (Federal Register vol. 52:158,30743-30745). We believe that it has some serious conceptual defects with regard to its application to patient populations with multiple diseases or multiple trauma. While we applaud the effort to apply statistical methodology to this problem, the present effort has sufficient flaws as to make it inappropriate to be utilized for these disease categories. Expanded research efforts should be made to define a more valid model, perhaps the Bayesian model indicated below, and public presentation of conclusions derived from the present method should be withheld until verification by the medical, surgical and statistical community is complete. In accordance with public policy on this issue, we would like our comments published in the Federal Register.

Examining comparative mortality data can identify ways of improving quality. Nevertheless, differences in hospital mortality rates do not themselves indicate differences in quality unless the patient populations in the institutions evaluated are comparable with regard to severity and unless the proportion of cases within each disease category to be compared are equivalent and randomly selected for review to eliminate sampling bias. Differences in mortality may either be a result of a different proportional mixture of the types of diseases treated by the hospitals, or may be due to differences in the severity of the illnesses treated. The methodology used by HCFA does not take adequately into account either of these factors. The analysis method used assumes a single basic diagnosis per patient, whereas in some patient groups, especially in the severely injured multiple trauma patients there may be multiple system and organ injuries each with its own morbidity and mortality probability, plus any associated pre-existing co-morbidities due to age, or associated disease.

Moreover the use of a linear logistic model for the estimation of the probability of survival assumes that there is a single data direction which best separates survivors from deaths. However, the preponderance of medical data in this disease suggests that this is not so especially if physiologic covariates were considered, as they should be. For example multiply injured patients with cardiogenic decompensation shock may die of a hypodynamic low cardiac output syndrome, whereas patients who succumb from severe septic complications of trauma frequently die in a hyperdynamic cardiovascular state with metabolic dysfunction due to the multiple organ failure syndrome. These physiologic factors interact with the anatomic injury pattern and the age related factors in a non linear fashion where the variable directions may not be orthogonal as assumed in this methodology.

Similarly, patients with multiple trauma may have summations of probabilities of survival which do not follow a linear logistic model, since as noted these are based on nonlinear interactions between injury pathophysiologies and are dependent on the pattern of organ damage and the associated physiologic system dysfunctions. For instance, the mortality of patients with both brain injury and femoral fracture is significantly greater than those with isolated central nervous system injury alone and this mortality increases as a function of additional associated injuries. Also, the maximum likelihood method of estimating the coefficients which is used in the published methodology, while minimizing the residuals over all the cases, tends for this reason to underestimate either survival or death, which ever is less prevalent. A Bayesian model of the probability of outcome, based on actual histograms of the past likelihood ratios of survival versus death for each diagnostic category, may be a more accurate representation of the posterior probability of survival or death against which actual hospital outcomes for patients within a given disease and injury strata can be compared.

Finally, the methodology described does not make clear what procedure is used or what its administrative implications are. What is the reason for selection of 10 and 90 or 5 and 95 per cent points? Some readers will be misled into thinking that a hospital with mortality at, say, the 98% level has a higher mortality than 98% of hospitals. This is not true. The method appears to be correctly using a procedure that models the fact that there is both random variability of the nationwide estimates and also variability (due to chance selection of patients) of any hospital's actual performance around its capability. The probability applies not to the hospital but to the HCFA. Its meaning is that if an institution is at the 98% point then the HCFA runs a 2% risk of error if they assert that the institution's mortality rate is higher (by an unspecified and possibly small amount) than the expected. This whole issue should be carefully set out in a decision theoretic context with the various risks of error explicitly specified and open for public discussion. For example, HCFA might incorrectly determine that an institution has a high death rate when it does not. It might fail to so determine this for an institution that does. Similarly for low death rates. What are these risks and how do we want to deal

with them? With such important questions regarding the validity of the statistical methodology as applied to complex disease process such as multiple trauma, it would seem appropriate that more research to develop an appropriate statistical model should be carried out before potentially misleading and almost certainly invalid comparisons between institutions with differing patient populations of multiple traumatic injury are conveyed to the public.

Very sincerely yours,

John H. Siegel, M.D.
Professor of Surgery, University of Maryland
Professor of Surgery, Johns Hopkins University
Director, MIEMSS Clinical Center
Deputy Director, MIEMSS

William P. Coleman, Ph.D.
Associate Professor, Department of Mathematics and Statistics, University of Maryland, Baltimore County
Director of Mathematical & Statistical Research, Maryland Institute for Emergency Medical Services Systems (MIEMSS)

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7600 Carroll Avenue • Takoma Park, Maryland 20912 Telephone (301) 891-7600

October 27, 1987

William F. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Re: Washington Adventist Hospital
Response to HCFA Mortality Data

Dear Dr. Roper:

Washington Adventist Hospital, having received and carefully reviewed the HCFA Mortality Data, wishes to submit the following comments with respect to those statistics.

The original data compiled by HCFA indicates that 210 of the 3,188 Medicare patients admitted to Washington Adventist Hospital in 1986 died within 30 days of admission. Of these, 187 died while a patient of the hospital and 23 died following discharge. In all diagnostic categories, the hospital's mortality rate was within or below HCFA's predicted range.

A review of Washington Adventist Hospital's records indicates that 3,035 Medicare patients were admitted to this institution in 1986, including 208 of the 210 listed by HCFA. Presumably this discrepancy in total Medicare admissions is attributable to the fact that HCFA included patients admitted in 1985 who were discharged in 1986. Hospital records also indicate that 189 of these 208 patients died at this institution and 19 discharged alive.

Subsequent to record review, the Quality Assurance Department verified with physician offices that 3 of the 19 patients, reported as deaths within 30 days of hospitalization, did indeed expire. Four patients reported as deaths following discharge actually died in the hospital. Attempts to verify the remaining 16 patient deaths were unsuccessful.

Washington Adventist Hospital would like to point out that it provides two intensive services unique to Suburban Maryland, radiation oncology and an intensive cardiac/open heart program. Severely ill patients are transferred to Washington Adventist to receive treatments such as radiation therapy, cardiac catheterization, angioplasty and cardiac bypass surgery. It should be noted that deaths in the pulmonary disease category frequently had underlying cancer or coronary disease.

In 9 of the 17 categories, less than 5 deaths were reported in 1986; it is difficult to draw accurate conclusions from such a small sample size.

Washington Adventist Hospital performs a systematic, ongoing review of patient care and has elected to participate in the statewide Quality Indicators Project sponsored by the Maryland Hospital Association.

Thank you for providing us with the opportunity to respond to the data.

Sincerely,

R. D. Marx

Ronald D. Marx
President

WASHINGTON COUNTY HOSPITAL ASSOCIATION
CARING TOGETHER
251 East Antietam Street • Hagerstown, MD 21740-5771 • (301) 824-8000

William L. Roper, M.D.
Administrator
Health Care Finance Administration
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D. C. 20201

October 27, 1987

Dear Dr. Roper:

The Washington County Hospital Association is in receipt of the HCFA Mortality Data 1986. After internal review and verification of the data, the following errors have been identified:

I. Incorrect Patient Age

[redacted] CE 88 M 12/11/86 12/12/86 12/12/86 431 Correct age - 97

[redacted] CE 98 F 04/06/86 04/06/86 04/06/86 436 Correct age - 93

[redacted] GC 73 05/19/86 05/23/86 05/23/86 578. 9 Correct age - 72

[redacted] GU 78 M 06/06/86 06/12/86 06/12/86 600 Correct age - 79

[redacted] HM 86 M 05/16/86 06/23/86 06/08/86 428 Correct age - 84

[redacted] HM 66 M 07/14/86 07/19/86 07/19/86 428 Correct age - 64

[redacted] PN 100 F 03/28/86 03/31/86 04/09/86 5070 Correct age - 70

[redacted] PN 100 F 03/28/86 03/31/86 04/09/86 5070 Correct age - 99

[redacted] PN 86 F 03/01/86 03/04/86 03/05/86 415. 1 Correct age - 70

[redacted] SE 89 F 05/04/86 05/14/86 05/22/86 03842 Correct age - 90

[redacted] UN 65 F 01/04/86 01/09/86 01/09/86 4590 Correct age - 66

II. Incorrect Date of Death

[redacted] CA 71 F 01/31/86 02/18/86 02/19/86 20288 Correct date of death - 02/18/86 Disp. code 07

[redacted] HM 84 F 03/20/86 04/03/86 04/04/86 4280 Correct date of death - 04/03/86 Disp. code 07

III. Incorrect date of discharge

[redacted] HL 85 F 02/10/86 02/23/86 02/24/86 4049 Correct date of discharge - 02/24/86

IV. Incorrect date of discharge and date of death

[redacted] PN 93 M 04/26/86 05/03/86 05/03/86 4860 Correct date of discharge and death - 05/02/86

V. Incorrect principle diagnosis

[redacted] HS 75 M 10/14/86 10/20/86 10/20/86 4275 Correct princ. diagnosis - 7890

[redacted] TR 50 F 03/03/86 04/10/86 04/10/86 82009 Correct princ. diagnosis - 03842

VI. Incorrect admission date, discharge date

[redacted] SE 88 M 12/11/86 12/18/86 01/01/87 [redacted] Correct adm. and disch. dates - 12/25/86 01/01/87 (this patient had a subsequent 1986 admission than the one reported)

COMMENTS REGARDING DATA

The public release of mortality and other hospital data presents an excellent opportunity for open and productive communication between Washington County Hospital and the patients it serves. Since Washington County Hospital is committed to the cost-effective delivery of quality health care it is seeking to ensure that the community understands the significance of the data as well as the limitations of its usefulness.

We would like to emphasize that the HCFA mortality data should be used by hospitals to identify or suggest areas for further review not to make judgements regarding high or low quality care. Comparisons of actual and predicted mortality rates can only suggest that the hospital and its medical staff review an area to determine if a quality problem exists.

The statistical model developed by HCFA measures the relationship between a limited number of patient characteristics and the risk of death. These characteristics include: principal diagnosis, presence of certain selected complicating illnesses, patient's sex and age, number of times that the patient was admitted to the hospital during the preceding twelve months, and whether the patient was transferred from another hospital.

The model does not include measure of severity whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment for a terminal illness, or the patient's general psychological or health status.

The data used by HCFA indicates that a total of 2,907 Medicare patients were treated in 1986. Our own records indicate a total of 4,428 Medicare patients treated during 1986. The discrepancy may reflect multiple admissions of the same individual. The data used by HCFA indicates that a total of 347 Medicare patients died within 30 days of admission. Of these, 287 died while still a patient at the hospital, while 60 patients died after discharge.

In all of the diagnostic categories, Washington County Hospital's actual mortality rate falls within the range of the predicted mortality rate.

After an internal review of each patient's medical record, our statistics indicate that 45% of the 347 patients who died had severe enough medical conditions to require treatment in one of the intensive care units at the hospital. Our review also indicates that 12% of the 347 patients who died, were admitted with a terminal illness and received treatment in the hospital's Hospice Program. In addition, 15% of the 347 patients who died were admitted form a nursing home.

Of those patients who died while still in the hospital, our review indicates that 77% were categorized in the "high risk" diagnostic grouping. Of these high risk patients, 34% of them died within 72 hours of admission. After further review of their medical record the severity of illness was such that the patient was given a "grave prognosis" at the time of admission.

The review of quality of care is the responsibility of each hospital. At Washington County Hospital the Quality Assurance Program accomplishes this through a number of methods only one of which is mortality review. Quality of care review can only be accomplished by a thorough review of each patients' medical record. This is done on a daily basis by a staff of trained nurse reviewers who use a set of "generic outcome screens". These screens identify potentially unnecessary or inappropriate care. When a case "fails" the screen, this in itself does not identify unnecessary or inappropriate care, it only flags the case for further review and evaluation by the medical staff.

The review process at the medical staff level reviews all aspects of the outcome and identifies any deficiencies that may have existed. Should a deficiency be identified, then an action plan is initiated. The emphasis of any action plan is to improve clinical and technical performances which would then improve the quality of care.

This review process is ongoing and has been an integral program at Washington County Hospital since 1980 and its findings are reported to the hospital's Board of Trustees every 90 days. The responsibility of the Board is to oversee the entire program. Not only is there internal oversight but also external oversight by the Federal Government, the State of Maryland, and the Joint Commission of Accreditation.

It is our hope that this announcement will help the public understand how quality care is monitored at Washington County Hospital.

Sincerely,

Anne D. Mayhew, RN, CPQA.

Anne D. Mayhew, R.N., C.P.Q.A.
Utilization Review/Quality Assurance Manager
Washington County Hospital Association

TECHNICAL APPENDIX

METHODOLOGY

The Data Base

The basis for the present analyses is the MEDPAR file assembled and updated quarterly by the Bureau of Data Management and Strategy in HCFA. This file is constructed from information on hospitalizations submitted to HCFA by hospitals through fiscal intermediaries and from data obtained from the Social Security Administration describing certain characteristics of the patients including age, sex, race and the date of death. Because each Medicare beneficiary is assigned a unique health insurance claim number (HIC), it is possible to link hospitalizations longitudinally to ascertain prior and readmissions, and the date of death whenever and wherever it occurred.

The process of data management consisted of the following steps:

(1) admissions to acute-care hospitals were selected, as was the array of data needed to characterize the patient and the hospitalization;

(2) the first- and last-occurring hospitalizations, their nature as out- or in-transfers, and the number of admissions prior to the last of a given patient in a given calendar year were identified,

(3) patients were assigned to major diagnostic categories by means of the principal diagnoses, their additional diseases identified on the basis of the secondary diagnoses, of which there were up to four for each hospitalization, and separate files were written for each diagnostic category for the first- and last-occuring hospitalization respectively. Analyses were performed on the separate files. For the purpose of assessing overall mortality rates, results obtained for the individual diagnostic categories were aggregated. As a check on the programming, a summary file of the hospital-level data was also written and analyses of this summary file were compared with the results of aggregation of the files for the diagnostic categories.

In this project, the basis used for the assessment of mortality rates was death within 30 days of admission. However, because readmissions can occur within the interval between admission and 30 days thereafter, to avoid multiple counts of deaths, the last-occurring admission in a calendar year was chosen because it is associated with the highest risk of death. The prior experience of the patient was taken into account by identifying whether the last-occurring admission represents a transfer from another acute care facility and by identifying the overall number of prior hospitalizations in the year.

The composition of the diagnostic categories and of the comorbidities was determined in part empirically and in part on the basis of clinical judgment. The diagnostic categories used in these analyses were chosen to follow medical disciplinary lines and to report principally on high-risk admissions but also on certain low-risk admissions. The empirical testing consisted of the computation of the relative risk of death associated with the category or comoribidity compared to that isn a reference population by using standard statistical techniques (The Cox Proportional Hazards Model). A committee of clinical advisors was assembled to review alternatives and to assist in the design of an appropriate classification scheme. The approach adopted for the present analyses is the result of their deliberations and advice.

A list of the ICD9-CM codes included in each diagnostic category and comorbidity is found on the following pages.

Analytic Techniques

The principal analytical tool was logistic regression. Because the diagnostic categories are mutually exclusive, the analyses to ascertain the influence of patient characteristics (age group, sex, comorbidities, prior admissions and transfer status) were carried out separately for each category. If p is the probability of a given patient dying within 30 days of admission, its dependence on the patient's characteristics x_i (covariates) is specified by the logistic model as

$$\log \frac{p}{1-p} = \Sigma_i b_i * x_i .$$

Once the coefficients b_i have been computed, it is possible to estimate the predicted probability of dying for that patient, and, by averaging over all the patients whose treatment in a given hospital is being evaluated, the predicted mortality rate for that hospital for the individual diagnostic category as well for all categories taken together.

The second quantity required of the analyses was an estimate of the uncertainty in the mortality rate expressed as a range of predicted rates encompassing a specified proportion (95%) of the probable values. For this it is necessary to compute the variance of the probability of death at a given hospital. This quantity is conventionally taken to consist of the sampling variance and of the variance due to the uncertainty in the estimates of the regression coefficients. The latter, given the very large populations used to estimate the coefficients, is negligible compared to the former, and was confirmed to be so by direct calculation.

	DIAGNOSIS	ICD-9-CM CODES*
High Risk		
CA	Cancer	141-160, 162-172, 174-209
CE	Stroke	430-432, 434, 436
HS	Severe acute heart disease	410, 427.1, 427.4, 427.5, 441.0, 441.1, 441.3, 441.5, 441.9, 785.51
HM	Severe chronic heart disease	398.91, 402.01, 402.11, 402.91, 425, 428, 518.4
GC	Gastrointestinal catastrophes	551, 557, 560.0, 560.2-560.9, 570, 572-572.7, 573.4, 567, 578.0, 578.9
ME	Metabolic and electrolyte disorders	250.01-250.4, 251.0, 251.1, 255.4, 276
PN	Pulmonary disease	415.1, 416.0, 480-483, 485-516, 518-519, except 516.1, and 518.4
RN	Renal disease	580-590 except 580.81 and 590.81
SE	Sepsis	DRG: 416, 417
TR	Severe trauma	806, 808.43, 808.53, 820, 821, 828, 850.2, 850.4, 851.1-851.7, 852, 839.0-839.5, 860-867, 887, 897, 900.0, 901-904, 926, 927.0, 928.0, 929.0, 942.3, 942.4, 942.5, 946.3-946.9, 947.1-947.9, 948.2-948.9, 952, 958.0, 958.1, 958.4, 958.5
Low Risk		
EY	Ophthalmologic disease	360-379
GY	Gynecologic disease	617-629
HL	Low risk heart disease	393-429, except 415.1 and 416.0 and cases in categories HS and HM
GI	Gastrointestinal disease	530-579, except 577.0, 573.1 and 573.2 and cases in category GC
GU	Urologic disease	593-609
OP	Orthopedic conditions	712-739, 810-838, 840-848 (excluding cases in category TR)
UN	All other Conditions	All other ICD 9 CM Codes

*All of the above entries refer to ICD-9-CM codes except for the entries for Sepsis which are expressed in terms of Diagnosis Related Groups (DRGs).

COMORBIDITY	ICD-9-CM CODES
Cancer	141-160.9, 162-172.9, 174-208.9
Chronic liver disease	571-572.8
Chronic renal disease	582-583.9, 585-587
Chronic cardiovascular disease	412-414.9, 426-429.1
Chronic pulmonary disease	491-493.9, 496
Cerebrovascular degeneration/ chronic psychosis	290-290.9, 294-299.9
Hypertensive disease	402-405.99, 412-414.9
Diabetes	250.01, 250.1-250.9

(A comorbidity is taken to be present if its ICD-9-CM code appears on the bill as any one of the up to four addtional diagnoses beyond the principal diagnosis.)

The sampling variance for the computation of the range of predicted mortality rates is approximately estimated by

$$[P * (1-P)]/N$$

where P is the proportion who had died of persons at risk, N, within a specified diagnostic category (or overall).

The (negligible) component of variance of the overall mortality rate, due to the regression coefficients is estimated approximately by

$$\Sigma_i[\Sigma_k\Sigma_{k'}p_{ijk}*(1-p_{ijk})*p_{ijk'}*(1-p_{ijk'})*x_{ijk}*C(b_i)*x_{ijk'}]$$

where the subscripts k and k' refer to individual patients, i to the diagnostic category, and j identifies the hospital. However, given the potential systematic differences among hospitals in the severity of illness of their patients, in the quality of care they receive and other unidentified factors, a further contribution to the variance, the interhospital variance, must be considered. This constant term is estimated by

$$IHV = \Sigma_j(P_j-\bar{P})^2*(N_j/N_t)*(1-1/N_j)$$

where P_j is the predicted mortality rate, N_j the number of cases at risk at hospital j, N_t the total number of cases at risk, and $\bar{P}$ the average mortality rate, in the category under consideration. In computations using standardized residuals, the sampling variance was based on the observed mortality rate. The difficulty engendered by the occurrence of a zero mortality rate in some hospitals was overcome by a Bayesian approximation in which the mortality rate, D/N, was replaced by (D+1)/(N+2), where D is the number of persons who died and N is the number at risk.

The ranges of predicted mortality rates given in this publication encompass 95% of the probable values on a logit scale to ensure that the range neither goes below zero nor above 100%. On the logit scale, the range of predicted values, P, is given by

$$R = \log \frac{P}{1-P} \pm 1.96 \frac{\sqrt{[P*(1-P)/N + IHV]}}{P*(1-P)}$$

Retransformed to the linear scale, the upper end of the range is

$$\exp(R_+)/(1+\exp(R_+))$$

and the lower end of the range is

$$\exp(R_-)/\exp(1+R_-)$$

where R_+ is the value of R taken with the (+) sign and R_- is the value of R taken with the (-) sign.

Two subsidiary analytical approaches were employed both as checks of the programming and the computational algorithms, and as validation tools. One was multiple linear regression in which the unit of observation was the hospital, the dependent variable the proportion of persons at risk who had died, and the independent variables within the specific diagnostic categories the proportions of the persons at risk within given characteristics used in the logistic regression. Thus, a direct comparison of the results of the logistic and the linear models was made in the case of the specific diagnostic categories. However, whereas in the computations based on logistic regression results for overall mortality were simply obtained by aggregation of the specific categories (including "Other"), in multiple linear regression analysis of this quantity, the diagnostic categories were used as covariates, along with the other patient characteristics.

The other alternative approach consisted of indirect standardization of mortality rates. The population at risk in each diagnostic category was subdivided by age-group and sex into cells within which average mortality rates were calculated. These rates were then used to compute predicted mortality rates for the age and sex-mix of each hospital.

In addition to the above, cross-validation and boot-strap analysis were used to explore the properties of the models in selected diagnostic categories. In cross-validation, the entire population at risk is randomly divided into two equal subsets and regression analyses are performed on each subset. Predicted mortality rates for the hospitals are computed both directly within each subset and by use of the patient characteristic of a given subset and the coefficients obtained in the other subset. This approach essentially tests the reproducibility of the estimation of the regression coefficients. In boot-strap analysis, replicate populations are constructed by sampling with replacement from each hospital's population. These replicate populations are of equal size but differ from each other in case-mix. Regression analyses are then performed independently on each boot-strap replicate.

Rank-order (Spearman) correlation coefficients of standardized residuals, the difference between the actual and predicted mortality rates divided by the standard error of that difference, were used to compare the results of the various analyses. In addition, the reproducibility of the identification of "outliers", hospitals whose standardized residuals were above +1.96 or below -1.96, was evaluated by ascertaining what fraction of outliers found in one year were still outliers in a subsequent year and what proportion of outliers on first-occurring admissions in 1986 were also outliers when last-occurring admission were analyzed.

SUMMARY

The tabulation of the numbers of cases at risk (i.e. the number of patients whose last discharge in 1986 was from the given hospital), of the percentage of these persons who died within 30 days of the date of admission for that hospitalization, and of the range of predicted mortality rates encompassing 95% of the probable values on the logit scale forms the core of the present publication. The observed overall mortality rates of approximately 4% of the hospitals place them more than 1.96 standard errors above the rate predicted for the case-mix of the patients of that same hospital. However, this quantity is very dependent on the precise formulation of the variance. If the interhospital variance is omitted, the number of "high outliers" rises to about 11%. In contrast, the number of "high outliers" computed by means of multiple linear regression is 2.5%. However, the variance, or more precisely, the standard error appears to behave as a scale factor affecting the shape of the distribution but to have little influence on the position of a hospital relative to the others. Thus, the Spearman correlation coefficient of residuals and of standardized residuals is about 0.95, i.e., the order is determined predominantly by the residual itself, the difference between the observed and the predicted mortality rates.

The stability of the predicted mortality rates when the case-mix of the hospital is held constant is attested to by the results of cross-validation: the Spearman correlation coefficients of standardized residuals calculated from the vector of covariates and regression coefficients estimated in the same subset with standardized residuals obtained from the same vector of covariates but regression coefficients estimated in the complementary subset are 0.99 or higher for various diagnostic categories including the most heterogeneous, cancer. In contrast, the Spearman correlation coefficients of standardized residuals obtained in successive boot-strap iterations, in which the case-mix of the hospital is allowed to vary but other characteristics are implicitly held constant, lie in the range 0.6-0.7. The implication of this last, which bears importantly on year-to-year stability of rankings, is that there remain important causes of variability in outcomes associated with variations in patient characteristics (such as severity of illness) and other factors that have not been taken into account in the models used in the present analyses.

Comparison of standardized residuals obtained by logistic regression at the patient level and by linear regression at the hospital level yields Spearman correlation coefficients that lie in the range 0.92-0.99 for the specific diagnostic categories. For the overall mortality rate, the Spearman correlation coefficient is 0.83. However, in this instance the logistic and linear model are specified differently. In the

logistic model, the results for overall mortality are obtained by simple aggregation of the results of the analyses of the specific diagnostic categories, plus the category "other", whereas in the linear model the diagnostic categories are treated as covariates. A rank-order correlation coefficient of 0.89 is also obtained when overall mortality assessed by indirect standardization is compared with the results of logistic regression. Multiple linear regression gives a convenient estimate of predictive power in the proportion of the variance accounted for by the model. For last-occurring admission and specific diagnostic categories this lies in the range of a few percent to 37%, the latter applying to the category "cancer." For overall mortality, this quantity is 59%. Almost the entire (95%) predictive power of the model for overall mortality is accounted for by ten patient characteristics: age over 85, severe acute heart disease, sepsis, pulmonary disease, cancer as a comorbidity, cerebrovascular accidents, renal disease as a comorbidity, metabolic and electrolyte disturbances, severe chronic heart disease, and age between 70 and 74.

The validity and utility of the approach used herein is best tested by comparing the results of analyses of first-and last-occurring admissions in the same calendar year and of patterns observed in successive years. When comparing first-and last-occurring admissions it is important to note that about two-thirds of hospital patients have only one discharge in a given calendar year and that one-third have multiple admissions. Therefore, some correlation will be forced by the overlap of first and last-occurring admissions. The average probability of death within 30 days of a first-occurring admissions in 1986 was 6.9% and that for the last-occurring admission was 11.7%. Clearly, these hospitalizations are associated with very different risks. For 1986 discharges, the Spearman correlation coefficient of standardized residuals for first-and last-occurring admissions was 0.83. In addition, about two-thirds of the hospitals identified as high outliers for first admissions were also high outliers based on analysis of outcomes of last-occurring admissions (71% if the interhospital variance term was not used in the calculation of the standardized residual and 64% if it was).

The Spearman correlation coefficients of standardized residuals for last-occurring admissions in 1985 and 1986 were 0.61 (0.57 if the interhospital variance component is included in the variance) and 0.51 (0.48) when 1984 and 1986 rankings are compared. The concordance of high outliers in 1985 and 1986 was 48% and for 1984 and 1986 it was 44%.

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